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THE JOURNAL
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IOWA MEDICAL SOCIETY

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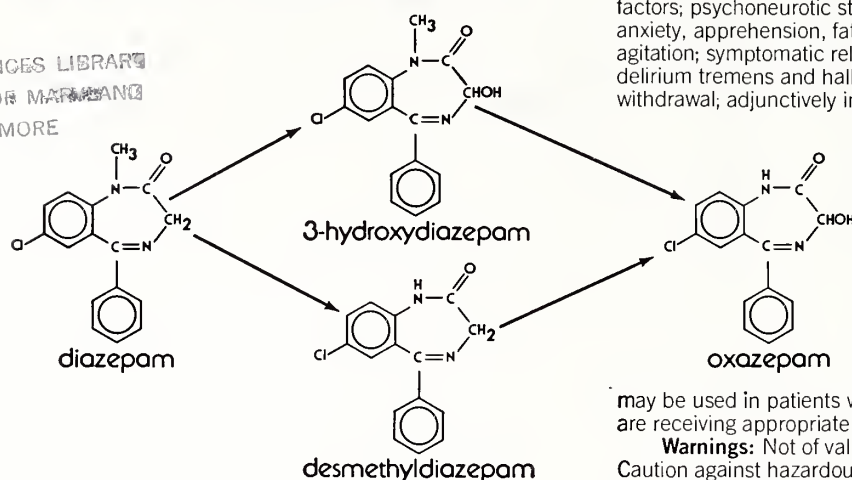
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JANUARY 1977

A pharmacokinetic character all its own

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Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



Roche Laboratories
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IOWA Medical Miscellany

AETNA PROPOSAL . . . Better than 800 replies are in hand from Iowa physicians in response to a December survey to determine the viability of an IMS-sponsored professional liability insurance program proposed by the Aetna. The overwhelming majority of the respondents indicated a willingness to consider participation in the program if the provisions are beneficial. Plans call for the entire proposition to be reviewed January 13 by the IMS Medico-Legal Committee with a recommendation expected to be made to the Executive Council on January 27.

'77 LEGISLATURE CONVENES . . . Iowa's lawmakers begin 1977 deliberations January 10 with Democrats in control of both chambers. The Senate is 26-22 Democrat with two seats to be filled by special election. The House is 60-40 Democrat. The IMS Committee on Legislation will meet January 6 to assess health-related matters on the eve of the new session. See the *Question Box* feature for an interview with Legislative Chairman D. C. Young, M.D., Des Moines.

ECONOMIC ISSUES . . . A "Statement of Responsibility in Health Care" has been approved recently by a Blue Cross/Blue Shield Cost Effectiveness Committee. This committee includes representation from the IMS. The six-page statement sets forth 10 guidelines to be pursued in helping assure that health care is (a) accessible, (b) of uniformly high quality, (c) in appropriate quantity, and (d) of fair and reasonable cost.

CONFERENCE SCHEDULED . . . Matters relating to medical practice in hospitals will be examined March 12 at a conference at the Des Moines Hilton Inn. The session is under the joint sponsorship of the Society and the Iowa Hospital Association. James Sammons, M.D., executive vice-president of the American Medical Association, and Alex McMahon, president of the American Hospital Association, will headline the program. More detailed info will be forthcoming.

LCM's APPOINTED . . . Nearly 200 Iowa physicians received letters of appointment in December as IMS Legislative Contact Men for 1977. The LCM communications program seeks to encourage and facilitate contacts between local physicians and their legislators on important health related issues.

HISTORICAL COMMITTEE . . . The IMS Historical Committee circulated a December request to county society presidents and secretaries asking for the names of physicians with a special interest in medical history. History buffs were urged to signify their interest to the Committee.

BACK IN IOWA . . . The health screening program sponsored by Farmland Coop and provided by American Health Profiles, Inc., has resumed activity in Iowa. The AHP program was offered in about 25 Iowa communities early last year. AHP representatives have been urged by the IMS to contact county medical society officers upon entry into a county.

SCANLON FOUNDATION . . . Loan commitments to 18 Iowans attending medical school have been made for the current academic year by the Scanlon Medical Foundation/Iowa Medical Society. The total loan obligation is for \$30,800.

SITE SURVEYS . . . Recent activity in the continuing medical education area has included two site surveys by the Society's Committee on Medical Education and Hospitals. The two applicants for CME accredited status include a Des Moines hospital and a state voluntary health organization. The accreditation program is a joint effort of the IMS and AMA.

PSYCHIATRIC CARE . . . The IMS Committee on Psychiatric Care expects to present a recommendation to the Executive Council January 27 reaffirming the Society's opposition to the creation of a new state department to be concerned solely with mental health.

(Please turn to page 18)

President's Page



Here we go again! Remember how Medicare and Medicaid were touted as the *do-all* and the *save-all* to assure health care for certain groups of citizens? Remember how elements of organized medicine, including this one, warned proponents of these schemes their fiscal and administrative dreams must be coming from a pipe and would some day flatten against reality? Remember how our warnings were condemned as self-interest, not as counsel from a profession that, after all, has long experience in providing health care?

Now we are hearing concern about Medicaid. Investigating authorities express horror as they learn how hustlers and promoters are taking advantage of the law. These opportunists are lumped together as "providers" and, of course, the providers include physicians. It is easy, using a broad brush, to cover all with the familiar paint of "guilt by association." Unfortunately, among some 300,000 of any calling, there will be some stinkers and we are not proud of our small percentage.

I will, in your behalf, state the IMS position on this matter as plainly as I can. Anyone, whatever his occupation, who obtains, from another party, money or other items of value to which he is not legally and morally entitled is a crook and should be dealt with as such. Any physician who charges for services he has not rendered, personally or under his responsibility, is a thief and should be exposed and prosecuted. The IMS, through its committees and Judicial Council, will pursue any complaint in this area.

It should be remembered the only authority the IMS has over its members is persuasion and the ability to suspend or revoke membership. It cannot restrict or revoke a license to practice. The power to do this belongs to the state.

We do object most strongly to the frequent insinuations and innuendos that there are many wrong-doers among us whom we tolerate and even protect. Anyone—governmental agency, news medium, ordinary citizen, or any other—who has proof or even reasonable suspicion of such dishonesty is invited to submit it to the IMS. We will do all in our power to find an answer.

James F. Bishop, M.D.

James F. Bishop, M.D., President

ON NATIONAL HEALTH INSURANCE

SURVEY 10 AVERAGE CITIZENS as to the structure and operation of a *national health insurance* program and you'll probably get 10 different responses. The point of this assertion is that while the phrase is one of long standing, the general understanding of what it means is not all that good. To the unknowing the words *national health insurance* have a panacea sound: *All the health care you want—no out-of-pocket cost, no insurance payments—just another smooth government operation.*

Even the NHI proponents shy away from utopian rhetoric of this magnitude. Totally nationalized health care delivery will mean great uncertainty for the country. We will be forced to grapple with a costly and bureaucratic creature which in time may reach unrivalled proportions. Any movement in this direction should be examined with super care and with full knowledge of the ultimate ramifications.

If the preceding language seems ominous and frightening, that's exactly what's intended. To be forewarned is to be forearmed.

Regardless, the medical profession—that body of individuals most deeply concerned with health care delivery in this country—is not going to turn its collective back on the consideration of those various approaches which have been submitted by the planners, the legislators, the economists, etc. The physicians recently reaffirmed their intention to be in the arena.

In December, the medical profession's major policy-making body, the American Medical Association House of Delegates, debated and adopted a report calling for continued support of the Comprehensive Health Care Insurance Act of 1975 (H.R. 6222). This AMA-conceived measure is one of six or seven existing NHI proposals which range from extreme to moderate in amount of government domination and financing.

This action of the AMA House (Iowa has three voting delegates) means the medical profession

will be advocating its position—as strongly as possible—if and when NHI comes up in 1977. With the election of a new Congress and the pending inauguration of a new president, it appears increasingly likely that some form of national health care is in the offing.

Much to the surprise and dismay of many who regard the medical profession as totally opposed to and reactionary toward any such legislation, this December action of the AMA House is nothing new. It is a reaffirmation of a national health insurance philosophy first adopted in the late 1960's. The plan (popularly known as Medicredit) has been promoted in the legislative halls for several years and will be the physicians' vehicle again in 1977. Principal among the plan's 15 basic guidelines are the following:

- *Any national plan should build on existing private insurance and should not operate as a government service.*
- *The plan should be financed by private payments for insurance coverage for those with ability to pay and from general tax funds for low income groups.*
- *There should be minimum federal involvement in the administration and financing.*
- *The benefits should be comprehensive, embracing both basic and catastrophic coverage.*
- *The plan should allow for the use of pluralistic forms of health care delivery.*
- *There should be state jurisdiction over licensure and certification of health personnel and regulation of insurance.*

Thus, as regards national health insurance, there will be a posture of involvement on the part of the medical profession as NHI deliberations go forward in Washington, D. C., in 1977. It is believed that active participation by physicians can be effective in shaping a proper national health insurance program which is in the interests of the people of Iowa and nation.

IN THE PUBLIC INTEREST

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JANUARY 1977

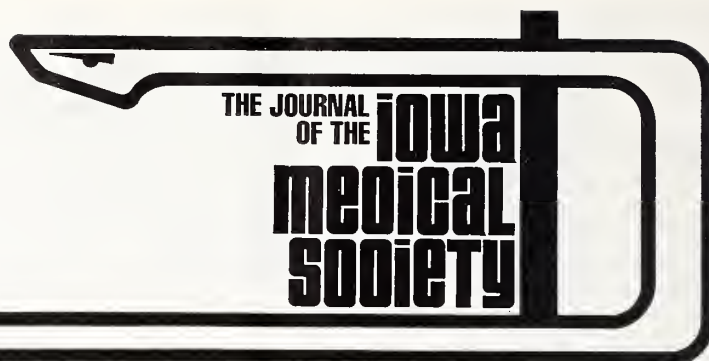


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The Question Box



by DONALD C. YOUNG, M.D.

Donald C. Young, M.D., of Des Moines, is the veteran chairman of the Society's Committee on Legislation. His brief responses here are offered on the eve of a new session of the Iowa General Assembly.

This month marks the beginning of another session of the Iowa General Assembly. What is the highlight information?

The Iowa General Assembly will convene Monday, January 10. There will be 26 Democrats and 22 Republicans serving in the Senate with two seats still in the elective process as this is prepared. There are 59 Democrats and 40 Republicans in the House of Representatives with one seat in contest.

What about the leadership positions?

In the Senate, the majority party will have George Kinley (Des Moines) as floor leader; Joe Coleman (Clare) as president pro-tem; Earl Willets (Des Moines) and Lowell Junkins (Montrose) as assistant floor leaders. In the House, the Democrats will have Dale Cochran (Eagle Grove) as speaker; Jerome Fitzgerald (Fort Dodge) as majority floor leader; Donald Avenson (Oelwein) as assistant floor leader.

The minority leader in the Senate will be Calvin Hultman (Red Oak); Elizabeth Shaw (Davenport) and Roger Shaff (Camanche) will be assistant minority leaders. In the House, Floyd Millen (Farmington) will continue as minority leader; Andrew Varley (Stuart), Joan Lipsky

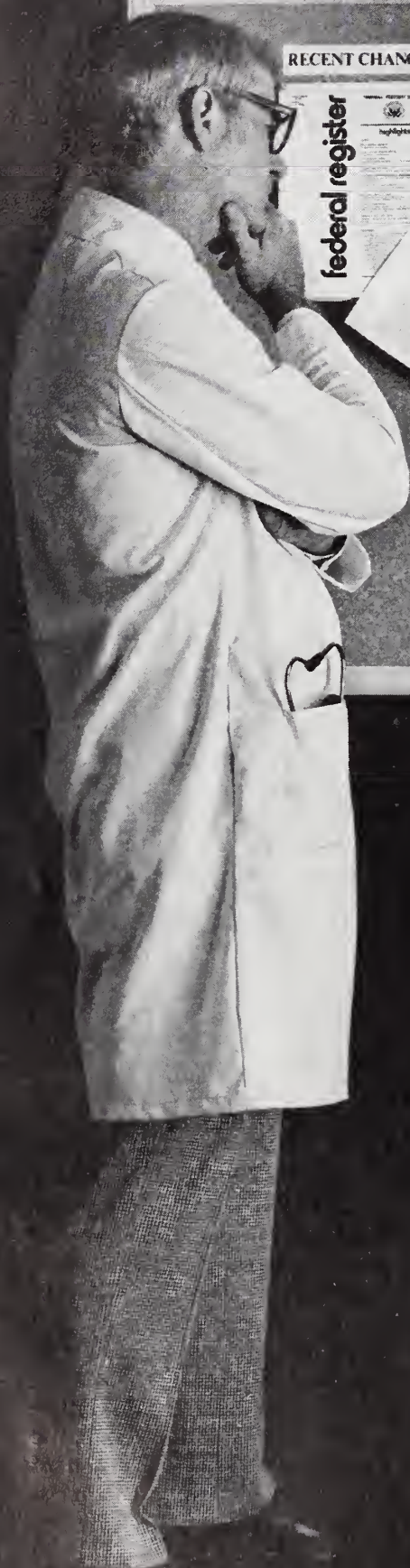
(Cedar Rapids), and Delwyn Stromer (Garner) will be assistants.

Is the Iowa Medical Society prepared to be active legislatively?

We certainly will attempt to follow closely the key health issues and be supportive of those which are in the public interest. In December nearly 200 Iowa physicians were appointed to serve in 1977 as IMS Legislative Contact Men. Communication from constituent to legislator (as represented by the LCM program) is the most appropriate and desirable way to gain support for a particular issue. We urge the LCM's and all physicians (a) to become acquainted with their legislators and (b) to transmit information on legislation of specific importance to the delivery of health care.

What matters are on the 1977 legislative priority list of the Iowa Medical Society?

A meeting of the Society's Committee on Legislation is scheduled for January 6 to go over the legislative schedule. Many familiar measures will be coming up again this session. We plan to request the Assembly's consideration of additional tort reform legislation in the professional liability area; the activity here appears likely to be broadened to include product, municipal and other forms of liability. We expect to be supportive of adequate funding for the Medicaid program and for the Family Practice Residency program. Other health related subjects that may receive consideration include radiation control, the compulsory immunization of children; a patient bill of rights; the use of drugs by optometrists; the expansion of chiropractic; a certificate of need bill, to name a few. It looks like another busy session.



RECENT CHANGES

federal register

Providing Drug Information to Physicians

Informational Bulletin #433-76

National Health Insurance

Special report Malpractice Insurance:

drug bulletin

Health care doesn't need more red tape

Drug firms challenge MAC rules

Drug Substitution

The Common Denominator of Health Progress
RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

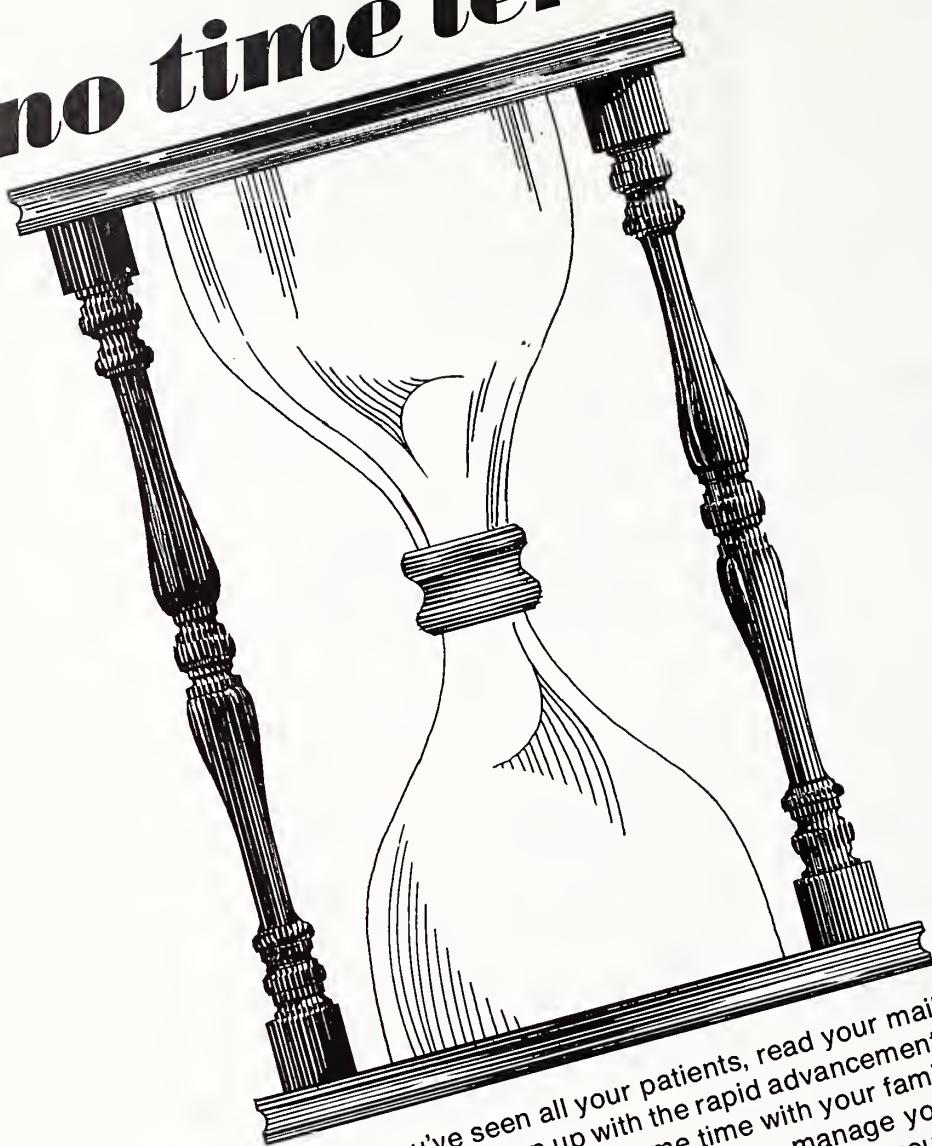
If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

no time left?



After you've seen all your patients, read your mail and journals to keep up with the rapid advancements in your profession, spent some time with your family and a hobby, is there no time left to manage your finances? Or is it the other way around . . . you handle your finances at the expense of family and relaxation?

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CAN SAVE
YOU TIME
AND MONEY





SCIENTIFIC ARTICLES

Importance of Recent Legislation Regarding the Recognition of Brain Death, And the Identification of Organ Donors

RICHARD L. LAWTON, M.D., and
JOHN DAVIS, B.A.

New Iowa laws are expected to facilitate the recovery of kidneys and other vital organs for transplantation. The authors highlight the new statutes and comment on organ retrieval procedures.

FOR THE PAST SEVERAL YEARS, the Iowa Medical Society Committee on Transplantation has recognized the need for legislation relating to brain death in Iowa. The Committee has also advocated driver's license identification of potential organ donors. The Society has worked with the Kidney Foundation of Iowa and others to encourage these actions by our state legislators. We are able to report that both proposals were approved by

Richard L. Lawton, M.D., is Professor of Surgery at the University of Iowa College of Medicine, and Chairman, Iowa Medical Society Committee on Transplantation. John Davis, B.A., is Executive Director, Kidney Foundation of Iowa.

the Iowa General Assembly during its 1976 session.

The law providing a space on the driver's license to identify organ donors will become effective January 1, 1977. At the time of licensing (or re-licensing) each individual will have an opportunity to indicate his or her willingness to donate parts of the body upon death. If a licensee opts to be identified, he must also have on his person an organ donor card which "wills" his organs to a physician, or an institution beneficiary. This should create considerable interest in organ donation and may even instigate inquiries from family members of potential donors.

The brain death law, which goes into effect January 1, 1978 reads as follows:

Section 208. NEW SECTION. DEATH. "Death" means the condition determined by the following standard: A person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, that person has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS
THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JANUARY 1977.

have ceased, a person will be considered dead if in the announced opinion of two physicians, based on ordinary standards of medical practice, that person has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

The Iowa General Assembly is to be congratulated for its recognition of the need for action in this area for the good of the community. Although the recognition of brain death is important for organ recovery and transplantation, it is equally important in making decisions regarding continued artificial support in hopeless situations.

In the past, the diagnosis of brain death has been accepted by the medical and lay communities. The diagnosis of irreversible brain death antedated, by many years, the utilization of vital organs for transplantation. The difference has been that brain death was not formally recognized by the law even though the medical and lay communities deemed it a logical termination of existence.

120 NEED TRANSPLANT

The need for cadaver organs for transplantation is apparent. At this moment there are approximately 120 patients in the state who require a cadaver organ transplant. Each year nearly 100 new patients suffer end-stage renal disease. Eighty percent of those new patients require a cadaver organ transplant. An ever increasing supply of cadaver kidneys is needed to meet the expanding demand from a larger patient population. At present the supply falls far short. In fact, over the six-year experience of the Iowa Transplant Service, barely 1/10 of the organs needed have been recovered.

In a study conducted several years ago, the Kidney Foundation of Iowa found that more than adequate numbers of brain deaths are reported in Iowa to allow timely transplantation of practically all those who need a kidney. However, we have been able to utilize only a small fraction of the potential numbers. This is due to many factors, such as: *lack of public awareness and understanding of organ donation, physician reluctance, economic disincentives for hospitals, and logistical problems.*

We can report significant progress in each of these areas. The Kidney Foundation of Iowa conducts a vigorous public education program and has distributed well over one million donor cards.

The Iowa Transplant Service has established a refined system of logistical support for organ recovery. Also, the federal government covers 100% of the transplantation costs for almost every recipient, including the full cost of organ recovery. The cost of recovering kidneys is even covered if the kidneys are medically unsuitable and are not transplanted.

And, most importantly, the recent passage of the brain death statute may relieve some of the reluctance of physicians to participate. Every Iowa physician should be aware that brain death has been given exactly the same legal recognition (except that two physicians must diagnose it) as traditional or "natural" death. This has significance whether or not organ recovery is a factor.

STATEWIDE RECOVERY

Organ recoveries have been made in a number of communities outside of the Iowa City Transplant Center. The first organ recovery from a cadaver was made in Fort Dodge, Iowa late on Tuesday, November 28, 1972. The next satisfactory out-of-center organ recovery was made in Spencer, Iowa and since that time kidneys have been recovered in Sioux City, Council Bluffs, Cedar Rapids, Dubuque, Davenport, Rock Island, Mason City and Des Moines. The organ recovery team is on the alert 24 hours a day in Iowa City and will respond to any potential donor situation. It is prepared to help manage the potential donor in the intensive care unit, and at the appropriate time, come to the hospital to make the recovery. The Iowa Transplant Service should be called immediately (319/356-1616) when a potential donor is identified.

A satisfactory donor is usually under the age of 50, has no history of hypertension or renal disease, no history of cancer with the exception of brain tumors, and is free of established infection. Very young donors, under the age of 5, are usually not acceptable. Some of the immediate laboratory information needed about a potential donor is the creatinine level, urinary output, blood pressure and blood type.

CLINICAL DIAGNOSIS

The diagnosis of brain death can be made on clinical grounds. It requires the recognition of deep coma, respirator dependency, and the loss of protective reflexes around the head and neck area which includes fixed dilated pupils, and the absence of cough, gag and corneal reflexes. The

law states that when, in opinion of two physicians, irreversible brain death has occurred the patient is pronounced dead. The physician may then approach the family and ask for permission for organ donation.

When permission is granted for a recovery, it is essential that blood be sent to Iowa City via the Highway Patrol for tissue typing of the donor. When this is completed recipients can be selected for the transplant. Detailed instructions regarding organ recovery and initial preservation have been distributed to all hospitals and physicians throughout the State, and are periodically updated.

After the diagnosis of brain death has been made by two physicians, they should individually note in the chart that the patient has expired due to irreversible brain death and state the time. Prior to the arrival of the recovery team, it will make contact with the intensive care unit and the operating room. The operating room will be alerted to the needs of the organ recovery procedure (most of them already know), and the team will generally fly to the site of the recovery. Recovery requires the presence of an anesthetist or someone who can manage the respiratory and cardiovascular systems. It ordinarily takes about

3 hours for a recovery. After the excision of the kidneys the respirator is turned off and all function ceases. If the eyes have been donated, they can be removed at this time.

SUMMARY

In summary, irreversible cessation of spontaneous brain function (brain death) has been given equal recognition under the laws of Iowa with cessation of heartbeat and respiration. This has significance for all decisions regarding artificial life support. However, its most positive impact will be in facilitating the recovery of kidneys or other vital organs for transplantation. The need for such kidneys in Iowa is great and this new law should expand the potential for recovering kidneys throughout Iowa.

Those physicians who serve on the Iowa Medical Society Committee on Organ Transplantation include R. L. Lawton, M.D., Iowa City, J. T. Bakody, M.D., Des Moines, R. J. Corry, M.D., Iowa City, W. R. Hornaday, Jr., M.D., Des Moines, J. H. Jeffries, M.D., Waterloo, Alexander Matthews, M.D., Des Moines, H. B. Richeson, M.D., Iowa City, E. M. Smith, M.D., Des Moines, and G. G. Spellman, M.D., Sioux City.

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Diagnosis of a Brain Abscess By Computerized Tomography

FRANK M. HUDSON, M.D.,
GEORGE H. HOLMES, JR., M.D., and
MARK THOMAN, M.D.
Des Moines

Advantages of computed tomography are cited. Abscess localization is possible in nearly every instance. Surgical removal is then possible with minimal damage.

BRAIN ABSCESES have become relatively uncommon in recent years, and like other infectious processes, their treatment has been enhanced considerably in the last three decades by the use of antibiotics. However, despite high expectations for virtual elimination of any mortality from this disease with the use of antibiotics, the fact remains the condition presents a considerable threat to life, and in a recent series of 200 cases of supratentorial brain abscesses, a mortality rate of 40% was reported.¹ This has been attributed to two main reasons: first, inaccurate localization of the abscess, and second, inadequate use of antibiotics.

It is beyond the scope of this case report to present the natural history of the brain abscess, or to detail the various methods for surgical treatment. However, in brief, brain abscesses usually arise either (1) by contiguity and direct extension from infection of the paranasal sinuses, or mastoid cells, (2) secondary to infections arising after skull fracture, (3) or by metastasis from primary sources of infection elsewhere in the

body, such as a lung abscess, empyema, or bacterial endocarditis. There is another group which is considerably smaller, but significant, in which no known source for infection exists at the time of discovery of the abscess.

In early stages, a necrosis of brain tissue occurs amounting to an acute cerebritis, and with attempts to limit the spread of infection, a capsule may be formed. Any organism may be the offending one, but the common ones are the streptococcus, the staphylococcus, the coliform bacilli, and the pneumococci. Symptoms of an enlarging brain abscess are virtually the same as with any other lesion which is increasing in size in the brain, with focal signs depending on the area involved and the generalized signs of increased intracranial pressure being common. Seizures are by no means uncommon.

Localization of the brain abscess, heretofore, has depended chiefly on radiologic procedures of arteriography or ventriculography. However objections can be raised to either of these methods. Neither can be relied upon to provide accurate localization of the lesion, and both constitute invasive procedures, which are in themselves not altogether without hazard, particularly ventriculography. With the advent of brain scanning, another valuable tool was added to those available for diagnosis. Nevertheless, these methods have their limitations, as can be shown in this following report. It was only with the use of computerized axial tomography scanning that a completely accurate localization was achieved, and a preoperative diagnosis could be made.

CASE REPORT

The patient was a 17-year-old male who had the onset of a fever to 103 F (39.5 C), headache and nausea without vomiting. His white blood count

The authors are in private practice in Des Moines, Iowa. Dr. Hudson is a neurosurgeon, Dr. Holmes is a radiologist, and Dr. Thoman is a pediatrician.

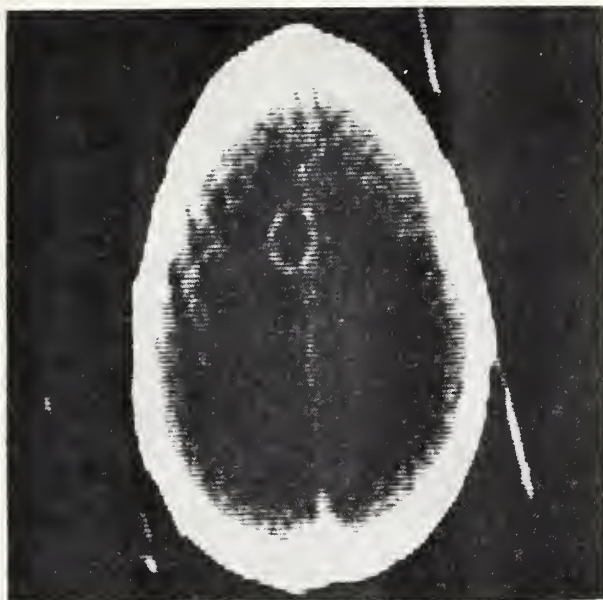


Figure 1. Without enhancement.

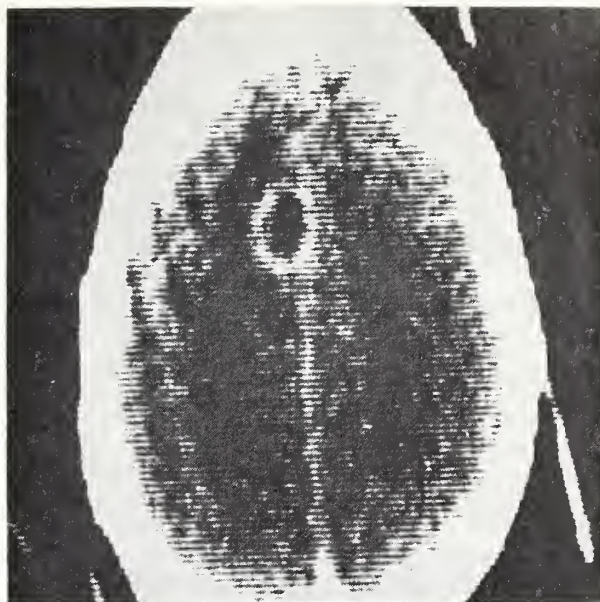


Figure 2. With enhancement.

COMPUTERIZED TOMOGRAPHY

Computerized axial tomography scanning was arranged with the cooperation of the Radiology Department of the University of Iowa Hospitals, and this was done the following day. This was reported as showing a mass lesion in the left posterior frontal brain, approximately 2½ cm in diameter and having the characteristic configuration of a brain abscess.

The computerized tomography scan without enhancement showed a region of low absorption in the left posterior frontal brain representing pus and cerebral edema (Figure 1). A repeat scan after intravenous contrast material demonstrated a zone of increased absorption between the pus and the perifocal edema and sharply outlined the abscess and its capsule (Figure 2). This "donut" configuration is quite characteristic of an abscess with a well developed capsule but can be mimicked by a very necrotic metastatic neoplasm and a few necrotic and cystic primary tumors. The clinical information leads to the proper differentiation between abscess and tumor.²

A left frontal craniotomy was then done with removal of an encapsulated brain abscess in the left posterior frontal brain at the level of abnormality of the brain scan. This was found to be present nearly 4 cm below the cortical surface and could be excised in its entirety. The culture showed a heavy growth of alpha streptococcus.

was elevated at that time to 21,000. The patient was initially somewhat lethargic, but the fever was gone in three days, and he improved to the point that he was able to go out with friends at the end of a week. The following week, however, he complained of increasing headache, and later of nausea and vomiting. He showed a rapid increase in lethargy progressing to semicoma within a two-day span. There was a history of head trauma, when he had fallen off bleachers during a football game, striking his head, some six weeks previously.

Lumbar spinal puncture had been done, which was thought to be traumatic because of poor cooperation on the part of the patient. The spinal fluid examination showed 179 RBC, with 5 WBC and 60% of these were lymphocytes. The glucose was 60 mg% and the total protein 62 mg%.

The patient showed extreme drowsiness, a markedly stiff neck, and a partial ptosis of the left upper lid. The funduscopic examination revealed blurring and elevation of the nasal disc edges. There was a right central facial paresis, and a near complete right hemiplegia. The deep reflexes were preponderant on the right side and there was a prompt right Babinski sign.

The possibility of a chronic subdural hematoma was considered.

Seldinger arteriograms were done promptly, which were not diagnostic.

The boy was placed on massive doses of appropriate antibiotics and after some period of continued somnolence, gradually became more alert and began to recover from the right hemiparesis. With physical therapy measures, he recovered the use of his right arm and leg, but remained with slight incoordination in skilled movements involving the fingers of the right hand, which subsequently cleared.

This case is felt to demonstrate the advantage of the computed tomography scan. Localization of

the abscess is accomplished in almost every case. In addition, the capsule of the abscess is shown in some cases. This is very helpful to the surgeon as it allows surgical removal of the lesion with minimum damage to the uninvolved cerebral tissue.

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Solving an Unusual Problem

JOHN H. SUNDERBRUCH, M.D.

Davenport, Iowa

Physicians encounter unique problems from time to time. This brief discussion is of one such case where ingenuity brought about a satisfactory outcome.

A PECULIAR MEDICAL PROBLEM often challenges the skills and ingenuity of the physician. This report is illustrative of such a peculiar situation.

A 64-year-old male appeared at the Emergency Room of Mercy Hospital, Davenport, Iowa, one evening with a highly unusual complaint. Someone reportedly had placed a circular machine bearing on his penis five days before. Examination demonstrated a markedly engorged, blue-black discolored penis with a machine steel bearing encircling the proximal portion of the organ. The distention of the penis was so great that the inner steel ring of the bearing could not be moved; the outer ring could be moved slightly in a circular manner upon the middle layer of ball-bearings (Figure 1). There was complete urinary obstruction.

How could such a problem be solved without

The author is in the private practice of medicine in Davenport, Iowa.

injury to the patient? Torches were out of the question; there was no way to use a usual type of saw. The local fire department had no special equipment for such an unusual situation. However, a fireman suggested the use of dental drilling equipment. A dentist was called. Using a portable dental drill, with a diamond disk saw, the bearing was cut into two parts enabling easy removal. More than two hours of sawing were required. The area was prevented from becoming



too hot by a continuous stream of water. The patient received Demerol to ease his discomfort.

After the bearing was removed, a Foley catheter was inserted into the urethra. In 48 hours the catheter was removed and the patient was able to void with ease. The only apparent residual of the entire ordeal were some abrasions of the skin of the involved area.

Cancer Case Counts for Iowa 1973-1974

JOHN W. BERG, M.D.

Iowa City

A 6% rise in number of invasive cancers is noted in this comparison of 1974 and 1969-71 statistics for Iowa. The total number of cases was 9,707, as compared with 9,139 in the earlier study. Greatest percentage increases were for the lung, bladder and pancreas.

PRELIMINARY COUNTS are now available for 1974 cancer cases in Iowa. We know they are incomplete to a certain extent. A few more cases always appear when hospitals are resurveyed or death certificates from later years are traced backwards. Also, access to Veterans Administration Hospitals was cancelled in mid year because of an excessively stringent reinterpretation of Veterans privacy rights at the national level, and access to records in one other of Iowa's 150 hospitals was denied. The resulting small degree of under-reporting for 1974 is likely to be balanced by a similar level of over-reporting of 1973 cases. The latter occurred because we had to omit registration of 1972 cases and so lacked our usual check on whether all 1973 admissions represented new diagnoses.

Normally new data are presented as incidence rates. This is difficult as always between census years because of uncertainties of population counts and more especially of the age distribution of the population. Cancer rates are so high in the aged that a small error in guessing the number of people

over 85 in Iowa can lead to a definite error in the age-standardized incidence rates. Dr. Maurice Griffel, an epidemiologist, is now working with the various population estimates and we hope his addition to our staff will permit fall publication of a full incidence report. In the interim it seemed worthwhile to present the case counts and compare them with 1969-1971 data.

There was a 6% rise in the total number of invasive cancers. Stomach and invasive cervical cancer continued to decrease as they have for at least 25 years. As expected, increases were seen for the major cigarette cancers: lung, pancreas, bladder and kidney. The rise in breast cancer well may reflect the increased interest in early

TABLE I
AVERAGE NUMBER OF NEW INVASIVE CANCERS PER YEAR
IN IOWA

	1969-1971*	1973-1974	% Change
All cases	9,139	9,707	+ 6
Large bowel	1,538	1,544	
Breast	1,232	1,380	+12
Lung	1,057	1,222	+16
Prostate	834	849	+ 2
Bladder	421	490	+16
Cervix	253	220	-13
Other uterus	363	414	+14
Ovary	241	248	+ 3
Kidney	187	208	+11
Mouth and pharynx	302	318	+ 5
Stomach	306	260	-15
Liver and bile ducts	145	142	
Pancreas	282	318	+13
Lymphomas	328	312	- 2
Myeloma	108	122	
Leukemia	360	348	
Melanoma	98	138	+41

* Final Third National Cancer Survey counts.

(Please turn to page 18)

Dr. Berg is director of the Iowa Cancer Epidemiology Research Center and is associated with the Iowa State Cancer Registry.

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(Continued from page 17)

detection of asymptomatic cases. Endometrial cancer continues to increase here as elsewhere lending importance to the excess risk associated with estrogen therapy. We have not yet had time to look into the unusual rise in melanomas, the one major increase in a relatively uncommon cancer that has so far come to our attention in the new data.

In addition to the above invasive cancers we registered an average of 475 in situ cervical cancers, 122 other in situ cancers and 60 cases of polycythemia vera. As mentioned above we have scheduled a full report on this material to be distributed to physicians and hospitals this fall. In the meantime we will do our best to answer specific questions and welcome these as well as suggestions as to how we can make the best use of the information we are collecting (with all of your help) on Iowa cancers.

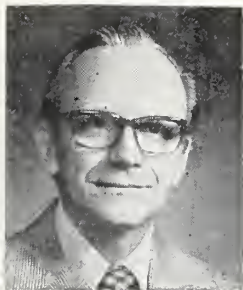
MEDICAL MISCELLANY

(Continued from page 3)

MEDICAID STATUS . . . A recently completed audit of Iowa Medicaid contains little or no critical comment on physicians' services. The report was done by the CPA firm of Haskins and Sells at the request of the Iowa General Assembly. Reference was made in the report to the need for identifying excess medical utilization with findings to be used for educational purposes. Percentage of Medicaid dollar going to MD's has remained just under 9% for the fiscal and calendar years. No program curtailment has been imposed even though a \$9 to \$10 million deficit is in prospect without a supplemental appropriation.

MEDICARE PROFILES . . . New profiles to pay Medicare B claims were put into use in October by Blue Cross/Blue Shield. New federal legislation has revamped the process by which prevailing charge screens for physicians' services are determined. While fee screens will be allowed to advance, the maximum will be 27.6% above 1973 fiscal year levels.

WAITING TIME . . . Average waiting in the physician's reception room is 20 minutes, according to the AMA's Ninth Periodic Survey of Physicians. General practice physicians had the longest waiting period of 27 minutes. Average wait for an appointment of a non-emergency nature is 7.3 days.



Editorials

M. E. ALBERTS, M.D., Scientific Editor

LIFE

What is life? What *is* life? What is *Life*? Which of these three words should be emphasized? "What" has a connotation of materialistic things. When one has wealth, and through that wealth, can purchase whatever is desired, those who are less fortunate may say, "Now, that is living the great life." However, the accumulation of material wealth may not always be accompanied with happiness, and love, and a true appreciation of life. "What" must express an identity of something more than wealth when related to "life."

"Is" means less—only a word to denote a state of being equal. But, is that really less?—a state of being equal asks the question of "equal to what?" Life is what? It is a state of being. Perhaps another way to express it is "life is what it's all about."

The dictionaries define life in several ways: "the quality that distinguishes a vital and functional being from a dead body"; "a spiritual existence transcending physical death"; or, "a principle or force held to underlie the distinctive quality of animate beings." So, what is this life? Perhaps we might consider only the ramifications of the legal problems regarding life or death.

This issue of the JOURNAL presents an article which summarizes legislation having to do with the recognition of brain death and the identification of organ donors. Death cannot be dealt with lightly. Death connotes the cessation of spontaneous respiratory and circulatory functions. Criteria are set forth for use in determining the manner in which death shall be ascertained. There are very pertinent facts that must be noted before a decision is made as to the state of life or death, i.e., if the findings are due to the effect of depressant drugs, primary hypothermia, or metabolic or en-

docrine disturbances. There should be no doubt that the state of being is due to irremediable structural brain damage. There could be a matter of doubt in some patients, and a sure diagnosis will require continued observation and investigation.

I would be remiss if I failed to comment about another aspect of life; the entire concept of our total *being* in society. The new year presents us with a new life. Some people make resolutions for each new year. Some cultures destroy all their old eating utensils and commence the new year with new dishes. The old is cast aside; the new greeted with anticipation and high hope. A re-evaluation may be made of the principles which distinguish us as being animate and viable. Some persons have principles which differ from those of other persons. Culture, social status, and the quality of lifestyle dictate the nature of those principles.

Numerous people have expressed their ideas of life. Jean Jacques Rousseau (1712-1778) said, "Teach him to live rather than to avoid death; life is not breath, but action, the use of our senses, our mind, our faculties, every part of ourselves which makes us conscious of our being." Thomas Jefferson, in a letter to James Madison in 1784, said, "Life is of no value but as it brings us gratification. Among the most valuable of these is rational society. It informs the mind, sweetens the temper, cheers our spirits, and promotes health."

We face a new year with many problems and many challenges. Our profession must confront these with a forthright sense of honesty and compassion, as well as the protection of our own rights and responsibilities. Our leaders must meet the leaders of industry, government, and other professions on a common ground for the ultimate good of everyone—not only the leaders, but for all they represent. The people as a whole must give support to the leadership for they cannot act

(Please turn to page 20)

EDITORIALS

(Continued from page 19)

alone. The words of Rousseau and Jefferson must serve as guiding lights into the darkness of the fu-

MEDICARE MILLS

We have diploma mills that grind out graduates by the dozens. We have marriage mills that produce marriages by the score. But what do *Medicare Mills* produce? More Medicare recipients? Hardly. Bureaucracy and social service departments have seen to that. *Medicare Mills* produce hundreds of unnecessary tests and x-rays on Medicare recipients.

What causes this? Greed, avarice, or worse? I don't know for certain, but I'd like to make a guess. I do not mean to condone or approve the practice—I only offer a theory of why; not an excuse.

Degrading a person causes him to lose self esteem. Loss of self esteem causes anger and hostility. I think that many doctors feel degraded by the use of the 75th percentile of a 1971 fee schedule.

I think they feel put down by never receiving

ture. Life goes on, and it remains complex. To face the future is like entering into a dense forest and therein to weave a wreath of memories. Should a tear come to your eyes as you do that, then you realize how great it is to be alive. That is what Life is all about!

Happy New Year!—M.E.A.

adequate compensation for their services. I think they feel frustrated by the tremendous amount of time spent in paper work on these claims. And I feel that they take their anger and frustration out on "the system" by running a "mill" of tests and exams. Justifiable? Certainly not—not under any circumstances.

Another character in this melodrama is the third party payor. The patient feels no responsibility for payment since someone else is paying the bill. I think this attitude rubs off on the doctor and soon he feels the same way. Someone else besides the patient will foot the bill and he orders many tests and x-rays. Is this right? By no means. But it has happened and maybe some of the things mentioned explain this.

Medicare Mills are a black eye on the face of medicine. They are not justified under any circumstances. But maybe "the system" will have to shoulder its share of the blame for this. I think it ought to.—DENNIS J. WALTER, M.D., *Des Moines*

POLLUTED WATERS

The lead article in the October 18, 1976 issue of JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* reported shigellosis from swimming in the Mississippi River near Dubuque. The report is the result of a masterful bit of epidemiologic sleuthing that is a credit to all involved in the study. Moreover, this report must impress upon us that people swim in some very contaminated waters. The "old swimming hole" is often the "old cesspool."

Increasing interest in boating and water skiing makes the problem even more apparent inasmuch

as skiers venture into areas not set aside for swimming. The continuing battle to prevent dumping raw sewage into rivers and lakes is never-ending. Many waters must be considered contaminated until proven otherwise. It is beyond my comprehension why some swimmers take this water into their mouths let alone swallow it. Surely, they wouldn't take a drink from the same source.

Though this is not the time of year when many are swimming in the rivers, lakes and pools of Iowa, it is imperative that we be cognizant of the dangers of contaminated waters. We must educate our patients and friends of the dangers of pollution. Environmental measures are very important, but common sense still has its place as well.—M.E.A.

* Rosenberg, M. L. et al: Shigellosis from swimming. J.A.M.A. 236:1849-1852, 1976.

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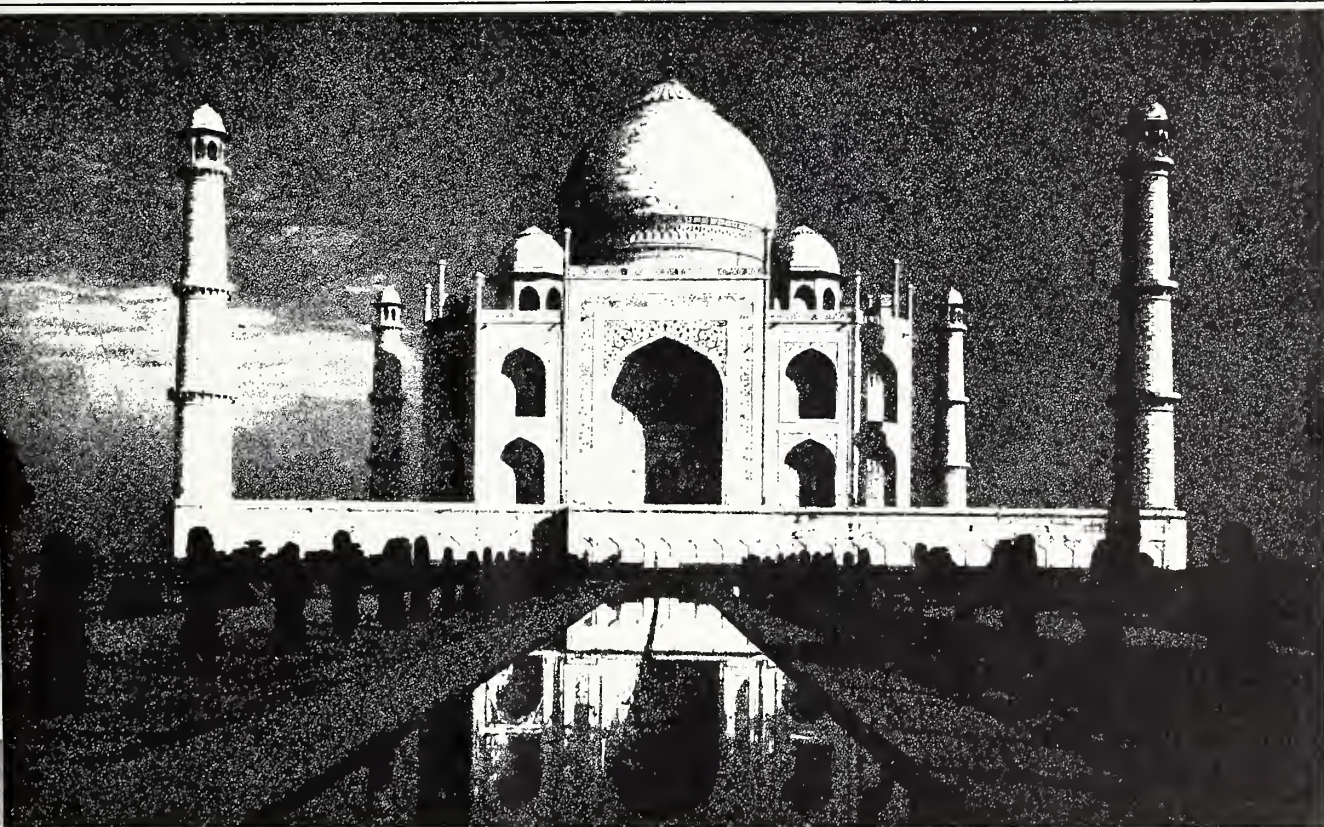
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Educationally Speaking

by RICHARD M. CAPLAN, M.D.

THE SIDEWALKS OF NEW YORK

Today I walked the sidewalks of Manhattan. I was in more of a hurry than I'd have wished, but I had to hustle if I was to reach both the theatre west of Broadway and the Morgan Library to see the exhibit that attracted me. And were it not for such pleasant opportunities, I wouldn't feel the ambivalence the city draws forth from me—I'd only despise it. That's because I'm a small town Iowan.

Although hastening past the throngs, I couldn't suppress some thoughts about New York, its special people and circumstances, and how those have implications for continuing medical education. What a difference the life style must make. Sure, there are great commonalities: a sore throat is a sore throat in either place (and even a small town doctor might meet up with a case of gonococcal pharyngitis), but what about the prospects for a traumatic interaction with a taxicab? And the exotic diseases that may be harbored by all those folk who by dress or speech reveal their increased propensity for foreign travel? And decades of breathing the smog? And the impact of life style: crowds everywhere and always, riding elevators to and from work on the 56th story, accepting or adapting to the uniquely abrasive and impatient ways of so many of the locals.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

ONCOLOGY TRAINING

The University of Iowa College of Medicine is offering interested Iowa physicians an expense-free opportunity for an individualized traineeship in oncology. The length of the experience would

At the meeting I attended, continuing education directors from the city complained of the woeful isolation from colleagues and hospital that befalls so many of *their* family physicians. I smiled complacently. That's rarely a problem for *mine*. They bewailed the bitter sense of cut-throat competition that exists in some of the more attractive suburban areas. I smiled with relative complacency. They moaned at the infrequency that continuing education arose in their locale from specifically documented needs or demonstrated deficits in patient care. At that my complacent smile vanished, for I know of very little CME in Iowa that arises organically from the careful study of medical practice that can reveal problems and knowledge gaps. (Translate "study of medical practice" as "medical audit.") And it is a well established principle of adult education that mature learners learn best and most efficiently when the educational content is related to their real-life need to function well at their own day-to-day tasks. In this particular, then, the average Iowa physician has the same long way to go that his megalopolitan counterpart has. I have a faith, though, in our Iowa doctors to learn how to achieve this "new approach" faster and in better spirit and good outcome than the city cousin. Maybe it's the clean air here. At least, I feel cheered to try it in Iowa, whereas in New York City, I'd likely throw in the sponge.

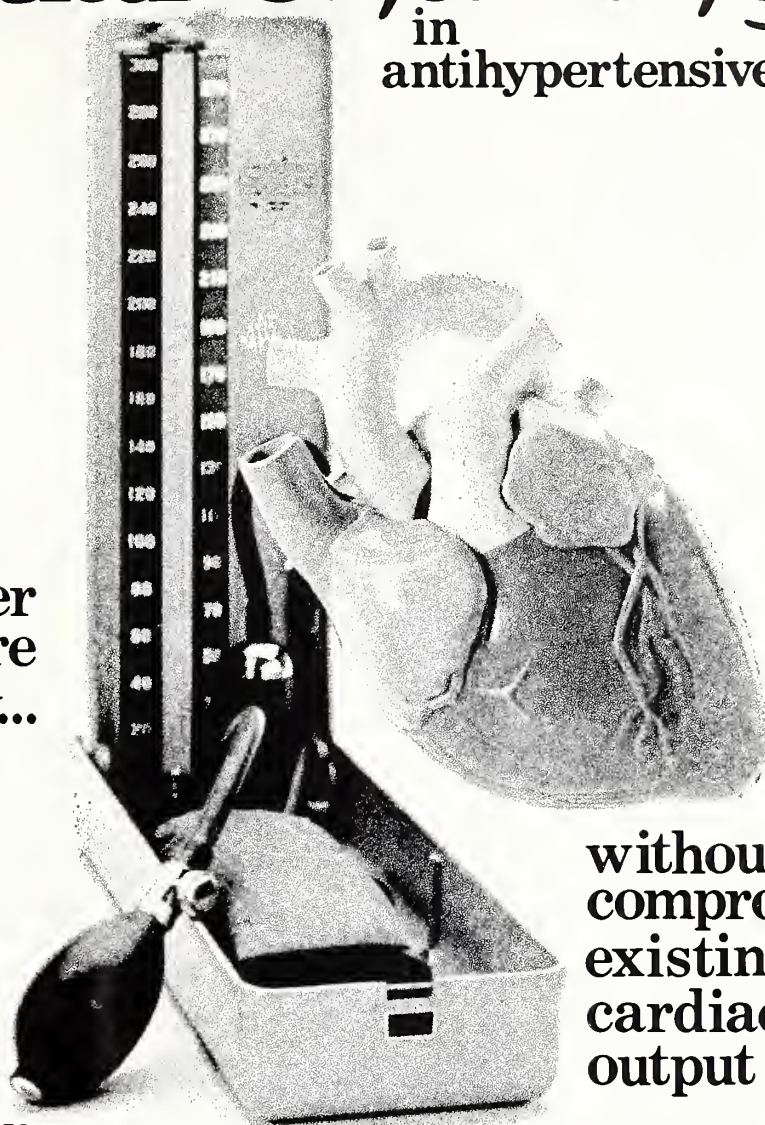
Corn, soybeans and hogs aren't the only things that can flourish in Iowa.

usually be several days and may emphasize various aspects of oncology, depending on the practitioner's interest. Continuing education credit hours (7 hours daily of Category I) are available. For information write the Office of Continuing Medical Education, University of Iowa College of Medicine, Iowa City, Iowa 52242.

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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Central nervous system: Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatulence, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (707)

MSD MERCK SHARP & DOHME

Refresher Course for the Family Physician

The 1977 Refresher Course for the Family Practitioner will occur in Iowa City February 15-18 under sponsorship of The University of Iowa College of Medicine and the Iowa Academy of Family Physicians.

The course is accredited for 29 hours by the American Academy of Family Physicians and for

Category I credit toward the AMA Physicians' Recognition Award. Full information is available from the Office of Continuing Medical Education, U. of I. College of Medicine, Iowa City, Iowa 52242.

Topics to be considered on the dates indicated are as follows—

TUESDAY, FEBRUARY 15

Common Oral Disease Problems
The New Antibiotics: Their Use and Abuse
Better Help for Patients With Atopic Eczema
Common Foot Problems
Athletic Injuries
Backache
Office Diagnosis of Adrenal Disease
Practical Aspects of Acid Base Imbalance
The Many Faces of Venereal Disease
Chronic Obstructive Lung Disease
Five of the Newest Laboratory Procedures
Management of Psychiatric Emergencies
Management of Pain in Cancer
Cancer Update on Breast, Prostate and Bowel
Leukemia in Adults and Children
Cigarettes and Other Short Cuts to Lung Cancer
Hodgkin's Disease 1977

WEDNESDAY, FEBRUARY 16

Family Counseling in a Busy Practice
Sex Counseling in the Family Physician's Office
Drug Levels to Monitor Drug Therapy
Alternatives and Supplements to Traditional Medical Practice
Computerized Tomography
Diagnosis of Hidden Abdominal Trauma
The Febrile Patient
Management of Asthma Today
Coronary Artery Bypass Surgery 1977
Can the Size of Your Patient's Infarction Be Altered After the Fact?
Cardiac Echocardiography
Myocardial Scanning for Infarction and Ischemia
New Angles in Glaucoma
Congenital Heart Disease Update
Advanced Life Support—What to Do After Resuscitation
How to Read an EKG
Radiographic Contributions to the Diagnosis of Appendicitis
Management of Depression in the Elderly
Diabetic Retinopathy
Simulated Patient Problems in Clinical Cardiology
Managing Eye Injuries
Knee Problems
Current Methods in Diagnosis and Management of Venous Disease
Caring for Patients With Spinal Injuries
Surviving on a Farm—Chemical Threats to Life

THURSDAY, FEBRUARY 17

The Pills—Panacea or Panic?
Drugs and Pregnancy—What Not to Rx
Anaerobic Infections in Obstetrics
Abdominal Pain in Children
High Risk Pregnancy
Fetal Monitoring
Management of Cardiac Arrhythmias
Steroids—An Update
Rheumatoid Arthritis
Iron Deficiency Anemia
Hypertension Management
Foreign Bodies in Children: Use of X-Rays in Diagnosis
Urolithiasis: Management of the Stone Passer
Migraine: Update in Diagnosis and Management
Enuresis: Drugs vs. Surgery vs. Alarms
Long Term Outlook for Patients With Chronic Renal Disease
Approaches in the Management of Peptic Ulcers
Gallstones: Medicine vs. Surgery
What Is a Significant Adnexal Mass?
How to Manage the Patient With Pelvic Pain
Prostaglandins—What's That?
IV and Oral Hyperalimentation
Five Iowa Physicians—Will They Be Alive in 10 Years?
Surviving on a Farm—Mechanical Threats to Life
Recruiting a Partner
Retirement Planning Workshop
Perennial Rhinitis
Recertification

FRIDAY, FEBRUARY 18

Hyperlipidemia in Children
S.I.D.S.
Management of Respiratory Distress Syndrome
Kids' Teeth—Why Fix 'em if They Get New Ones?
Liability Risk in Family Practice
Serous Otitis Media—To Tube or Not to Tube
Common Eye Problems in Children
Working the Short Kid Up
Inducing Labor
Long Term Outlook for Patients With Chronic Renal Disease—
Transplantation
Genital Herpes Simplex: Hot-Cold-Sores
Medical School Curriculum 1977
Medical Ethics Potpourri

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- ☐ α -ADRENERGIC ACTION REDUCES BRONCHIAL EDEMA AND SECRETIONS
- ☐ dosage forms to meet individual patient needs

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Each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer), and 25 mg phenobarbital in the immediate release layer

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

See next page for brief summary.

SUSTAINED ACTION



WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

T-GP-72-B/W

CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral SA: each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

STORE BETWEEN 59° and 86° F (15° and 30° C).

Full information is available on request.

Morbidity Report for November, 1976

Diseases	1976 1975 Most November Cases			Reported From These Counties
	Nov. 1976	to Date	to Date	
Amebiasis	14	50	20	Boone
Brucellosis	2	47	23	Dubuque
Chickenpox	679	10839	8149	Polk
Conjunctivitis	264	1941	1274	Scattered
Encephalitis,				
St. Louis	1	4	3	Marion
Erythema				
infectiosum	2	166	198	Lee, Story
Gastrointestinal				
viral inf.	6314	26542	21465	Davis, Linn
Giardiasis	15	40	25	Boone, Johnson
Hepatitis,				
A (infectious)	5	109	167	Polk, Linn
B (serum)	11	83	86	Polk
Unspecified	3	22	29	Linn
Impetigo	177	939	861	Scattered
Infectious				
mononucleosis	116	1025	1194	Johnson, Polk
Influenza-like				
illness	4713	48864	46487	Buchanan, Davis, Linn
Mumps	197	1527	1387	Black Hawk
Pediculosis	131	784	405	Scott, Story
Pinworms	9	32	—	Johnson
Pneumonia	108	948	1052	Scott
Rabies in animals	9	126	98	Scattered
Rheumatic fever	3	23	14	Clinton, Lee
Ringworm, body	17	240	293	Black Hawk, Johnson
scalp	3	22	10	Black Hawk, Clarke
Scabies	226	866	645	Scattered
Streptococcal				
infections	1055	13715	9072	Scattered
Tuberculosis—				
total ill	9	106	121	Polk
bact. positive	6	91	81	Polk
Venereal diseases:				
Gonorrhea	434	6043	6614	Linn, Polk, Scott
Syphilis	30	334	278	Scattered

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
Coxsackie B2 infection 3, Cytomegalovirus 2, Echovirus 1, Herpes Simplex 15

About IOWA Physicians

Dr. Enfred E. Linder, Ogden, has been named 1976 Dad of the Year at the University of Iowa. Dr. Linder is the father of three U. of I. students—daughter, Jean, third-year medical student; daughter, Jo Ellen, senior in pre-medicine; and son, David, a freshman. Dr. Linder received the M.D. degree at U. of I. College of Medicine in 1951 and started his practice in Ogden in 1953. Earlier this year he was selected by the Board in Control of the Iowa High School Athletic Association to receive one of the Association's first Team Doctor Awards. . . . **Dr. and Mrs. Glenn S. Rost**, Lake City, were honored recently at an open house. Dr. Rost is retiring after 30 years service as a surgeon in Lake City. A graduate of U. of I. College of Medicine, Dr. Rost completed his residency in surgery at Hertzler Clinic in Kansas. He is a diplomate of National College of Surgeons, a fellow of American College of Surgeons and a past president of Iowa Academy of Surgeons. . . . **Dr. Leonard Lamberty** has closed his office in Decorah and has moved to Wadena, Minnesota. . . . **Dr. Jose Amorin**, formerly of Elkins, West Virginia, began the family practice of medicine in Perry in November. Dr. Amorin received the M.D. degree at U. of I. College of Medicine and completed residencies in surgery and family practice in Dallas/Fort Worth, Texas. . . . **Dr. Thomas A. Ericson**, West Des Moines, was guest speaker at recent meeting of Central Iowa Laryngectomy group. . . . **Dr. Kenneth K. Hazlet**, Dubuque, was recently re-elected to the United States Conference of City Health Officers.

Dr. John C. MacQueen, Iowa City, and **Dr. William D. DeGravelles**, Des Moines, were program participants at recent Iowa White House Conference on Handicapped in Des Moines. . . . **Dr. A. H. Downing**, Des Moines, chairman of IMS Committee on Safe Transportation, has been appointed to Citizens Motor Vehicle Advisory Council of Iowa Department of Transportation. The Council considers

legislative matters relating to driver's licensing and automotive safety programs. . . . **Dr. Arthur S. Grossman** began a family practice in Grundy Center in November. Dr. Grossman received the M.D. degree at the University of Washington in Seattle; and completed a family practice residency at University of Maryland in Baltimore. . . . At recent annual meeting of the American Academy of Psychosomatic Medicine, **Dr. Otto Della Maddalena**, Waterloo, was named a fellow of the Academy and received the Physician's Recognition Award. . . . **Dr. Donald E. Wolters**, Estherville and **Dr. Anthony S. Owca**, Centerville, were recently presented Silver Anniversary Citations by Creighton University Alumni Association for their 25 years in the practice of medicine and loyalty to Creighton University. . . . **Dr. Jack W. Brindley** has joined **Dr. Donald Berg**, Ottumwa, in the practice of orthopedics. Dr. Brindley received the M.D. degree at U. of I. College of Medicine; interned in the U. S. Navy; and completed an orthopedic surgery residency at the University of Nebraska. . . . **Dr. Alex W. Boone**, Davenport, is new member of Marycrest College Board of Trustees. Dr. Boone was the 1975-1976 chairman of the physician division of the Marycrest investment program.

Dr. James Young, New Hampton, was guest speaker at a recent Mason City meeting for pharmacists and physicians. "Clinical Pharmacy and Its Contributions to Improved Patient Treatment" was the topic of the program sponsored by University of Iowa College of Pharmacy and Iowa Chapter of American Academy of Family Practice, in cooperation with the Iowa Pharmaceutical Association. . . . **Dr. Herman Hein**, **Dr. Frank Zlatnik**, **Dr. Donald McCabe**, and **Dr. Mary Weinstein**, U. of I. College of Medicine faculty members, and **Dr. John McGee**, Fort Madison, and **Dr. J. J. McElwain**, Burlington, were program participants at a recent seminar on prenatal care for

physicians and nurses sponsored by the Burlington Medical Center. . . . **Dr. Russell Broholm** began a family practice in Perry in November. Dr. Broholm received the M.D. degree at U. of I. College of Medicine; interned at Akron City Hospital in Akron, Ohio; completed two years of internal medicine residency at Detroit Receiving Hospital in Detroit, Michigan; six month residency in pediatrics at Children's Hospital in Detroit; and eight month residency in obstetrics at Crittenton Hospital in Detroit. For the past 11 years, Dr. Broholm has been in general practice in Colorado Springs, Colorado. . . . **Dr. C. H. Denser**, Des Moines, was recently installed as president of Iowa Division, American Cancer Society, for two-year term. . . . **Dr. Dale Phelps**, Waterloo, presented a recent program on total joint replacement at recent meeting of Waterloo Technical Society.

Two Sioux City physicians, **Dr. John S. Tracy** and **Dr. Frederick J. Lohr**, were honored recently by Creighton University Alumni Association. Dr. Tracy was presented a golden anniversary citation for his 50 years in the medical profession, and Dr. Lohr was recognized for his 25 years in medical practice. Dr. Tracy received the M.D. degree at Creighton Medical School in 1926, and Dr. Lohr is a 1951 graduate of the medical school. . . . **Dr. Dale D. Morgan** has been elected president of medical staff at St. Luke's Methodist Hospital in Cedar Rapids. **Dr. Robert L. Swaney** is new vice-president, and **Dr. James W. Reintertson**, secretary-treasurer. All are Cedar Rapids physicians. . . . **Dr. Earl E. Zehr**, Clarinda, recently attended the 29th annual scientific assembly of the Missouri Academy of Family Physicians. . . . **Dr. Harold Moessner**, Oakdale, was guest speaker at recent meeting of Manchester Area Chamber of Commerce. Dr. Moessner spoke on U. of I. College of Medicine Family Practice Program. . . . **Dr. Ted Scurletis**, of the Iowa State Department of Health, spoke on sudden infant death syndrome at recent meeting of Iowa Sheriffs' and Deputies Association. . . . A gift-supported visiting professorship in psychiatry honoring the late **Dr. Andrew H. Wood** has been established at U. of I. College of Medicine. Dr. Wood was the second director of the University's Psychopathic Hospital, serving from 1928 to 1941.

Dr. James R. Young, former New Hampton physician, has relocated in Waverly, where he will be

associated with the Rohlf Memorial Clinic. . . . **Dr. Sam T. Donta**, Iowa City, was recently elected a Fellow of American College of Physicians. . . . **Dr. Robert Ryan** retired December 1 following 29 years of medical practice in Fairfield. Dr. Ryan received the M.D. degree at Rush Medical College in Chicago, Illinois and interned at City Hospitals in St. Louis, Missouri. Following three years of military duty in the Medical Corps during World War II, Dr. Ryan practiced medicine in St. Louis for a year, then located in Fairfield in October, 1947. . . . **Dr. Glenn S. Rost**, Lake City, retired October 31. A native of Red Oak, Dr. Rost received the M.D. degree at U. of I. College of Medicine and began private practice in Lake City in 1946. He is a past president of the Iowa Academy of Surgeons; diplomate of National College of Surgeons; and fellow of American College of Surgeons. . . . **Dr. Ramie Bernardo** and **Dr. Dan B. Ruiz** began a family practice in Sumner in November. Dr. Bernardo's training includes graduation from University of Santo Tomas in the Philippines; internship at Iowa Lutheran Hospital in Des Moines; and pediatric residency at Baptist Hospital in Nashville, Tennessee. Dr. Bernardo also did a general medicine residency at Wyckoff Heights Hospital in Brooklyn, New York; internal medicine residency at Fordham Hospital and completed a fellowship at Bellevue Hospital in New York City in cardiopulmonary medicine. Dr. Ruiz received his medical education at University of Santo Tomas in the Philippines; interned at MacNeal Memorial Hospital in Berwyn, Illinois; served a surgery residency at St. Vincent's Hospital, Staten Island, New York; and Nassau Hospital in Mineola, New York. Dr. Ruiz is a Fellow in the American College of Surgeons and certified by American Board of Surgeons.

Dr. K. L. Thompson, Oakland physician for more than 50 years, was honored by Oakland residents at recent open house. Dr. Thompson received the M.D. degree at University of Nebraska College of Medicine. Following his internship and a three-year practice in Omaha, he located in Oakland. Dr. Thompson is a life member of the Iowa Medical Society. . . . **Dr. William DeGravelles**, Des Moines, was the main speaker at annual meeting of Central Iowa Chapter of the Multiple Sclerosis Society. . . . **Dr. Julian M. Bruner**, Des Moines, retired December 31, 1976. Dr. Bruner received the M.D. degree at Rush Medical College in 1926; interned at Los Angeles County Hospital,

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Los Angeles, California; served residencies at Mayo Foundation, Rochester, Minnesota, and St. Bartholomew's and St. Thomas' in London, England. He located in Des Moines in 1934 and began a surgical practice with his father, Dr. H. A. Minassian. Dr. Bruner has the distinction of being the only American ever inducted in the Royal College of Surgeons. This honor was bestowed on Dr. Bruner in 1973.

Dr. Kenneth K. Hazlet, Dubuque, was reelected to Board of Trustees at U. S. Conference of City Health Officers. . . . Two Des Moines physicians, **Dr. Channah Kongtahworn** and **Dr. Lawrence F. Staples**, were recently named Fellows of the American College of Chest Physicians.

DEATHS

Dr. Robert E. Murphy, 52, Fort Madison, died October 9 at his home. Dr. Murphy received the M.D. degree at St. Louis University School of Medicine and served his internship and residency in obstetrics and gynecology at St. Paul Hospital in Dallas, Texas, and Grace Hospital in Detroit, Michigan. Dr. Murphy practiced in Fort Madison for 21 years. He was a past president of Lee County Medical Society and fellow of American College of Obstetricians and Gynecologists.

Dr. Norman C. Flater, 74, Floyd, died October 26 at Floyd County Memorial Hospital. Dr. Flater received the M.D. degree at U. of I. College of Medicine and began medical practice in Floyd in 1931. He retired in 1973.

Dr. Robert G. Carney, 62, 30-year faculty member of U. of I. College of Medicine, and head of Department of Dermatology for 15 years, died November 4 at University Hospitals. Dr. Carney received the M.D. degree at University of Michigan School of Medicine and completed his dermatology residency and internship at University Hospitals in Iowa City. Dr. Carney was a past president of Iowa Dermatological Society and member of American Dermatological Association and American Academy of Dermatology. He was chosen "Instructor of the Year" by senior medical students in 1954; cited in WHO'S WHO IN AMERICA in 1970; and received a special "To The Chief" award in 1971 from the Iowa Dermatological Society. He was the author of many scientific papers and co-author of a book on DERMATOLOGY FOR THE STUDENT AND PHYSICIAN published in 1955, and revised extensively in 1970.

Medical Assistants



by BETTY EHLERT, CMA-A

EDUCATIONAL SEMINARS

Siouxland Chapter Medical Assistants held an educational seminar November 6 at St. Luke's Medical Center in Sioux City. The program covered "Human Relations" by Ms. Sandy Sabel, Home Federal Savings and Loan Association; "An Introduction to Plastic Surgery" by Alf Jordan, M.D.; a question-and-answer session chaired by Mr. Michael J. Myers, legal counsel for Sisters of Mercy Health Corporation, and the film, "Detecting Breast Cancer Earlier." State President Lean-

na Rist, CMA-A, Des Moines, and D. B. Blume, M.D., president of the St. Luke's medical staff, also addressed the members.

Mason City Chapter held an educational seminar November 7. Speakers were Robert Pfeil, Ph.D., "Are You Communicating?"; Ray Miller, M.D., "Aspects of Hand Surgery"; Mrs. Val Collison, R.N., "Role of Enterotherapist"; David Little, M.D., "Intensive Care in the Neonatal Nursery," and Mr. Lyle Kelley, Executive Director of the Mental Health Center of North Iowa, spoke on "How Am I Doing?" A panel of five physician's assistants discussed the "Role of the Physician's Assistant."

'BOSS OF THE YEAR'

Robert C. Larson, M.D., was honored recently as 1976 "Boss of the Year" by the Des Moines Chapter. Dr. Larson was nominated by his medical assistants, Twila Thompson and Christine Bartkiw. Past advisors and newly certified medical assistants were also honored.

Theme of the Bosses Night party was the "Roaring Twenties" in keeping with the twentieth anniversary of the American Association of Medical Assistants. Music was provided by the Roosevelt High School band and many medical assistants were in "Roaring Twenties" costume. Robert Zeff, M.D., was master of ceremonies and Mrs. Frances Rosen, CMA-A, was chairman of the party.



BOSS OF THE YEAR—R. C. Larson, M.D., Polk County's Boss of the Year, is shown here with Twila Thompson, left, and Christine Bartkiw.

SELF-ASSESSMENT PROGRAM

A new self-evaluation program has been developed by the American Association of Medical Assistants Continuing Education Committee, in collaboration with the Certifying Board, and is now available. The Self-Assessment Program is

designed for practicing medical assistants and employs the same format as the Certification Examination. It consists of (a) questions to test individual knowledge, (b) a self-scoring mechanism for convenience, and (c) a rationale of answers to provide immediate feedback on performance. This self-evaluation program is available through the AAMA national office.

LIST YOUR WANTS

DOCTORS—THE NEXT MOVE IS YOURS . . . Midwest Medical, Inc. will provide you with more information about each opportunity than you have ever imagined possible. For the first time you can visually preview the Community and Medical Facilities of over 80 opportunities in the Upper Midwest, at ONE location. Saves you time, expense, and frustration. For a thorough appraisal of all factors involved, please accept our invitation to call. For discreet and confidential assistance contact M. A. Cornwall, M.D., MMI's Medical Director, or write: Midwest Medical, Inc., Lakeland, Minnesota 55043. 612/436-5161. Locum Tenens opportunities always available.

WANTED—FAMILY PRACTITIONER to join 8-man multi-specialty group. Excellent clinic and hospital facilities. Unusually progressive small community in which to live and raise a family. Excellent salary and benefits, partnership in twelve months, liberal vacation and meeting time. Contact Richard A. Callis, Administrator, McCrary-Rost Clinic, Lake City, Iowa 51449. Telephone 712/464-3194.

WELL ESTABLISHED MEDICAL AND SURGICAL GROUP desires to expand the Family Practice Department from four to six family practitioners. Salary first year—partnership second. No buy-in required. Check this one—it's an excellent opportunity in a good stable economic location with plenty of social, cultural and recreational activities. Contact either G. W. Glenn, Business Manager, or Robert A. Weyhrauch, M.D., 1125 West Fourth Street, Waterloo, Iowa 50702. Phone 319/234-1541.

OB-GYN, PEDIATRIC SPECIALISTS needed by 16-man multi-specialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., LaCrosse Clinic, 212 South 11th Street, LaCrosse, Wisconsin 54601.

PSYCHIATRIC RESIDENCY—Vacancies for positions for July 1, 1977 for those who have a regular Iowa license or can obtain one by reciprocity or via the FLEX. Prepare for career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, \$21,294; 2nd year, \$22,360; 3rd year, \$23,478. Intensity and diversity of training program appreciated best by personal visit. Contact T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call Collect 712/225-2594.

FOR SALE—Assortment of old medical books, dating back to 1888. Please address your inquiry to No. 1522, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

MUSCATINE, IOWA—Needs 4 family physicians, 2 obstetricians, anesthesiologist, ophthalmologist, otolaryngologist and general surgeon. Muscatine has a population of 23,000 and serves an area of 40,000. Construction has started on a new 4 million dollar addition to the hospital. Town is 30 miles from the University of Iowa and 30 miles from the Quad cities. 7 new physicians have located here in last 3 years and are continuing to make a determined effort to provide quality medical care to the community. If interested please send curriculum vitae and list of 4-5 references to David G. Kundel, M.D., Chairman, Recruitment Committee, 1501 Cedar Street, Muscatine, Iowa 52761.

OB-GYN, UROLOGY, AND ORTHOPEDIC specialties to join an established successful practice with 15-man multi-specialty group. Excellent group benefits; retirement plan; modern clinic facilities; progressive community with excellent educational system including two colleges; area population 75,000; great recreational facilities; must be board eligible or certified; Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

FOR SALE—Medco Dublett Machine—Model 70, 4½ years old, excellent condition. \$350. Contact Steven G. Kruse, M.D., Ballard Medical Center, P.C., 602 North Main, Huxley, Iowa 50124. Phone 515/597-2600.

INTERNIST—Excellent opportunity for active practice of general internal medicine. Four-man group in North Iowa. Midway between Des Moines and Minneapolis. Close to Lake. Excellent art museum and school system. Starting salary \$40,000 plus bonus. Modern hospital. 35,000 community with 100,000 drawing area. Phone collect 515/423-0244.

ASSOCIATE DIRECTOR FOR FAMILY PRACTICE RESIDENCY PROGRAM—The newly developed Black Hawk Area Family Practice Residency Program serving the Waterloo-Cedar Falls area needs an Associate Director to start in February, 1977. This will involve teaching and supervision of Residents plus direct patient care. New 7,000 sq. ft. model office. The program is affiliated with the University of Iowa College of Medicine and offers an opportunity for a more relaxed practice of medicine plus academic advantages. Adequate salary plus fringe benefits equal to 20% of base salary. Ample vacation and opportunity for postgraduate study. Contact Charles A. Waterbury, M.D., Program Director, 635 Black's Building, Waterloo, Iowa 50703.

PHYSICIAN—UNIVERSITY HEALTH CENTER BY JULY 1977—Community of 120,000 serving 10,000 students plus spouses. Training in adult medicine and interest in sports medicine, no travel required. 40 Hrs., no call or night work. Excellent retirement and benefits. Director will be chosen July 1977 from medical staff. Send resume to J. Blumgren, M.D., Student Health Services, University of Northern Iowa, Cedar Falls, Iowa 50613.

OBSTETRICIAN-GYNECOLOGIST wanted to join two-man department in established 19-man multi-specialty group in Central Iowa. Immediate financial partnership. Outstanding fringe benefits. Regional hospital, excellent schools, recreational facilities. Write No. 1519, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

CARDIOLOGIST, UROLOGIST, ORTHOPEDIC SURGEON, and OPHTHALMOLOGIST wanted to join established 19-man multi-specialty group in Central Iowa. Immediate full financial partnership and outstanding benefits. Progressive community with regional hospital, excellent schools, and recreational facilities. Write No. 1520, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

OBSTETRICIAN-GYNECOLOGIST wanted by 15-man multi-specialty clinic. Good facilities. Medical school affiliation, if desired. New hospitals. Guarantees \$50-60,000 first year. Partnership thereafter. Write No. 1521, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

CONFERENCES FOR MEDICAL PROFESSIONALS—Over 500 listings of national/international meetings, conferences and seminars in the medical sciences for 1977. Send a \$10.00 check or money order payable to Professional Calendars, P. O. Box 40083, Washington, D. C. 20016.

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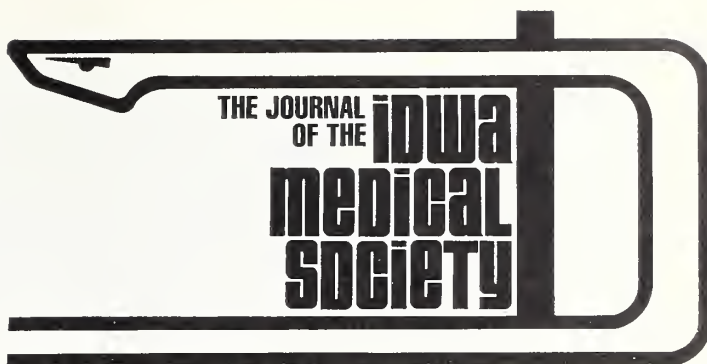
'77 SCIENTIFIC SESSION

Companies and organizations make good use of corporate seals, logos, trademarks, whatever. This effort to establish quick identification has merit.

You'll be seeing the adjacent and stylized array of letters periodically over the next few months. The IMS/-CME stands obviously for *Iowa Medical Society Continuing Medical Education*. It'll be used to make you aware of an exceptional 1977 opportunity to mix individual learning and family fun.

As the symbol says, the IMS Scientific Session is July 12, 13 and 14 at Telemark Lodge in scenic Cable, Wisconsin. Actually, the full week of July 11 is available to Iowa physicians at Telemark Lodge. A scientific potpourri is planned to include cardiology, endocrinology, caring for the pulmonary cripple, infectious diseases, scope of family practice, even a speech training seminar.

Bargain rates will be available to IMS members and their families. These were summarized in a January 10 letter from Society President J. F. Bishop, M.D. Dr. Bishop has urged all physicians to consider joining him for a great week in Wisconsin. It's a first-come reservation arrangement and space is limited. Contact IMS Headquarters for more info and registration forms.



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President's Page



The AMA House of Delegates voted in December, by more than a 2 to 1 margin, to present the 1977 U. S. Congress with a national health proposal. The debate was extensive, sincere and persuasive, on both sides. In its caucus before the House vote, the Iowa delegation determined its support for the position which ultimately prevailed. The Iowa delegation felt it wiser to be in the arena with a proposal than out on the perimeter in a totally negative stance.

* * *

The Scott County Medical Society invited area legislators to its January meeting. Most of them came. There was a useful exchange of views. Each legislator was asked to comment, and, without exception, each renewed the oft-heard plea for communication. I urge you again: Write your legislators, phone them, talk to them, tell them what you think. They are anxious to know.

* * *

Last year the Iowa General Assembly enacted a law which, under certain circumstances, permits pharmacists to substitute a less expensive generic equivalent for a prescribed medication. This possibility is eliminated by a "No substitution" notation on the prescription from the physician. In the case of Medicaid, the law uses the word *shall* in lieu of *may* with respect to a medication substitution. An interesting and difficult liability question presents itself here if an untoward development results from a substitution made by the pharmacist. Who's liable? The pharmacist? The physician? Both? The legislators?

James F. Bishop, M.D.

James F. Bishop, M.D., President

IOWA Medical Miscellany

LEGISLATIVE DINNER . . . Iowa's lawmakers will be hosted at a February 3 dinner given by the member organizations of the Iowa Health Council. The IMS is among the nine groups which comprise the IHC.

HANDBOOK PREPARATION . . . The 1977 Handbook for the IMS House of Delegates is in the preparatory stage with reports being received from the Society's approximately 40 committees. The Handbook will be distributed to all delegates in mid-March.

RESOLUTIONS . . . County societies planning to submit resolutions for consideration by the 1977 House of Delegates are reminded they must be received in February if they are to appear in the Handbook. Resolutions may be submitted beyond this point but they have less opportunity for study in advance of the House sessions. The 1977 House of Delegates will meet May 6 and 7 in Des Moines.

NOMINATING PROCESS . . . District caucuses will be occurring in late February and early March as the process of selecting 1977-78 IMS officers moves forward. Representatives to the 1977 Nominating Committee will be chosen at the caucuses, with the Nominating Committee scheduled to meet March 27 at IMS Headquarters in West Des Moines. The District councilors assume responsibility for conducting the caucuses.

PRESIDENTIAL TRAVELS . . . Society President J. F. Bishop, M.D., reported on IMS activities at county medical society meetings in Black Hawk and Woodbury counties during January. He will meet with the Benton County Medical Society February 8.

MEDICAL STUDENT LOANS . . . The Scanlon Medical Foundation/IMS has committed \$45,360 in loans to 26 Iowans attending medical school this academic year.

FEE ADJUSTMENTS . . . Iowa Insurance Commissioner Herb Anderson has approved an Equity Fee Adjustment Program submitted by Blue Cross/Blue Shield to aid those physicians hardest hit by professional liability insurance premium increases. This second EFAP will cover only Blue Shield regular business and is open to participating and qualifying physicians. A primary requirement for the EFA will be a professional liability premium increase of more than 500% during the past two years. Inquiries should be directed to Blue Cross/Blue Shield.

EXPAND HOME HEALTH CARE . . . Beginning about February 1 eligibility criteria for home care under Medicaid will be broadened. Service will be extended to patients needing maintenance care using this definition: "Health Maintenance—Patient's condition is stabilized. Needs physician plan of treatment, the review interval to be decided by physician on an individual basis. Requires observation by nurse for condition defined by the physician as indicating a possible deterioration of health status. . . ." This change should make Medicaid-reimbursed home care available to numerous additional patients.

CONFER WITH INDUSTRIAL COMMISSIONER . . . Medical aspects of the Workers Compensation Program were reviewed January 19 with Iowa Industrial Commissioner Robert Landess. Physician representatives of the IMS Committees on Industrial Health and Rehabilitation participated.

Famous Fighters



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INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to



neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Educationally Speaking

by RICHARD M. CAPLAN, M.D.

GRAFFITI AND GOETHE

Graffiti can be shocking, erotic, or enraging. More often it is just dull. Sometimes it's truly clever and funny. Once in awhile it is profound and edifying, especially when it takes the current popular form of modified graffiti that is hung on walls as poster art.

Today I saw such a poster with a quote from Goethe. Many people think of Goethe as a playwright, or a poet or a novelist. Indeed he was superb as a literary figure, and his influence on other artists of his time and later was immense. But his genius was multi-faceted, as genius and talent often are, and he is yet remembered in some quarters for his contributions to biology, in which he had formal training. His was one of the great minds of our epoch, and from such a mind might come observations on many things.

I don't know the origin of this particular quote in his writings, but I'm fairly sure he never wrote an essay on continuing education or learning theory. Nevertheless, it is an extremely insightful statement that any of us would feel proud to have conceived:

Until a man has learned to listen, he has no business teaching. Until he realizes that every man has something of truth and wisdom to offer, he does not begin to learn. It is only when he sees how each of his fellows surpasses him that a man

begins to be wise, to himself and to his fellow men.

Modern educational research has proven the truth of the second sentence. It underlies the desire of professional continuing medical education planners to make educational experiences as participative as possible. Experienced practitioners (in fact, adults in general) seem to like to share their viewpoints and experiences with others—they generally come away from such a session feeling more satisfied. More important, though, is what the others may learn. Interactive learning experiences in which everyone actively contributes are therefore viewed by continuing medical education people as optimal. The lecture hall with a huge audience listening to the emitted knowledge from an expert is thus the antithesis. This line of thought is what makes me try to arrange (as much as I can when I'm the program planner or a consultant to the planner) for a maximum of small-group give and take. The logistics of a convention or a continuing medical education course given at a major medical school often preclude what is optimal. That is why—and here is really the point of all I'm saying in this piece—continuing medical education professionals are trying increasingly to foster CME in community hospitals or other local settings where the number of learners and physical arrangements can permit so well the active participation of a small group.

If Goethe were to come back, wouldn't you much rather spend an hour engaged with him in discussion along with a small group of friends, than listen to him present a talk in a crowded lecture hall?

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

State Department of Health

CHANGES IN IOWA REGULATIONS FOR TITLE XIX (MEDICAID)

Effective February 1, 1977 eligibility criteria for home care under Title XIX were broadened. Two major changes are:

1. The requirement that a patient be home-bound has been removed.
2. Service will be extended to patients needing maintenance care by using the following definition:

"Health Maintenance—Patient's condition is stabilized. Needs physician plan of treatment, the review interval to be decided by physician on

an individual basis. Requires observation by nurse for condition defined by the physician as indicating a possible deterioration of health status. Example: Report a blood pressure reading above 150/110. Nursing fee for service is charged."

The above changes will make Medicaid reimbursed home care services available for numerous additional patients. Awareness by the home health agency of eligible people will depend in large part to the referral by physicians. Questions regarding this change should be directed to your certified home health agency (see map in article on page 45), or the Bureau of Medical Services, Iowa Department of Social Services, telephone 515-281-3359.

EXPAND PUBLIC HEALTH NURSING SERVICES IN IOWA

Public health nurses in Iowa provided 260,000 services to people in their homes in the 1975-76 fiscal year. In addition, the PHN's gave services in their offices, in schools, day care centers and at clinics. These general services were provided to people of all age and financial classifications.

A rapid expansion of public health nursing services has occurred in the past 10 years. In 1966, 215 public health nurses were employed in 41 counties and 18 visiting nurse associations. Less than one-half of Iowa's population had access to public health nursing services at that time. Currently, 357 PHN's provide services in 93 of Iowa's 99 counties and 97% of Iowa's population has access to these services. (See map.) The service is provided by:

- 183 PHN's in 84 county agencies (average of 148 full-time nurses);
- 92 PHN's in 13 voluntary agencies (visiting nurse associations);

- 67 PHN's in 3 combination agencies (Des Moines/Polk County; Cedar Rapids/Linn County; Sioux City/Woodbury County);

- 5 home health nurses in two hospital-based home care programs (Floyd and Cass Counties);

- 10 PHN's in 2 city agencies (Ottumwa and Dubuque).

Public health agencies are supported either by voluntary or official funds or a combination. They have similar programs. They have a single purpose to achieve a higher level of health for their communities by assisting in preventing, controlling and treating conditions that disable or cripple.

The public health nurse is a professional nurse with special education of public health. She concerns herself with all aspects of family and community health. She works closely with physicians, dentists, sanitarians, hospitals, social service and other community agencies. She assists in preventing illness by working with families and groups to encourage good health practices, i.e., optimal diet, adequate immunizations, regular medical and dental care, a safe sanitary environment. She provides health supervision to expectant mothers,

infants, preschool and school children and adults. Under a medical plan of treatment, she gives nursing care to the sick in their homes and supervises licensed practical nurses and home health aides who assist with home care. The PHN plans with community groups for health programs through discussion, radio, television, films and newspaper publicity.

PHN's in county agencies work under the supervision of regional supervisory nurses. These supervisory nurses also give advisory service to visiting nurse associations and school nurses.

PHN's do not charge a fee for educational services but may charge for care of the sick on a sliding scale according to the patient's ability to pay. Medicare, Medicaid, private insurance and social services pay for some calls. Free service is given when needed. The full fee for a nursing call varies with agencies, according to the cost for providing the service.

In the late 1960s, home care services began to increase rapidly. Studies show a well coordinated home care program expedites recovery from illness, prevents or postpones disability, shortens hospitalization, prevents re-hospitalization and helps to reduce the cost of illness. A cost comparison of home care and nursing home care was recently made by a group of public health nurses. The following is a summary of one of the cases:

Case: 88 year-old male living in his own home with wife, age 85;

Classification of Disease—Cardiovascular;

Living Conditions: Very small, old four-room home in rural town;

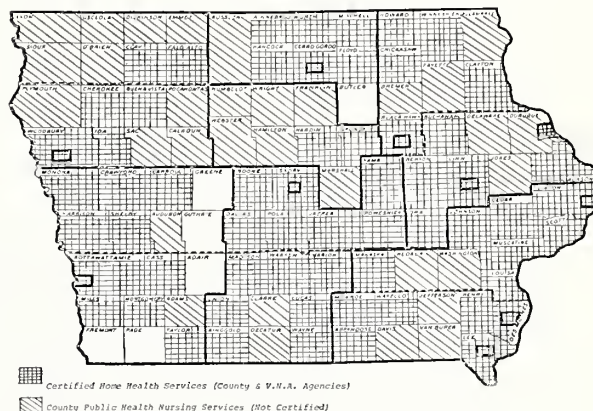
Referred by: Physician and admitted to nursing service in November, 1974;

Patient's Condition upon Admission: Able to be about home with help; however, prone to falling. Condition worsened, became unable to be up, was confined to bed, and had open draining area on left foot. His elderly wife found it difficult to care for him as he required much personal attention due to incontinence and progressing senility.

Public Health Nursing Visits: Were made every two weeks and home health aide service (every three to four days) was started in February 1975. The home health aide provided personal care and soaks to feet. Patient was hospitalized in November, 1975 for 11 days for confusion. Following that, home health aide services were increased to daily at which time patient was assisted into the wheel chair to be up each day. The public health nursing service provided diet instruction, moni-

toring of vital signs, medications and patient's general condition.

Patient's Present Condition: More alert. Area on left foot no longer has drainage. Enjoys being up in a chair and sits in the kitchen at the table. His wife is appreciative of help provided so they may stay together in their own home at ages 90 and 87. If this couple had not had public health nursing supervision and home health aide service, they would have been forced to be separated with placement of one in a nursing home.



Cost Factors: Following is a summary of the cost factors in this case and a comparison with nursing home cost:

<i>Public health nursing visits,</i>	
<i>November 1974 to May 1976 .</i>	<i>Cost: \$ 288.00</i>
<i>Home health aide visits</i>	
<i>(354 hours)</i>	<i>Cost: 1,459.35</i>
<i>Total home health care</i>	<i>Cost: \$ 1,747.35</i>
<i>Nursing home cost, November</i>	
<i>4, 1974 through May 31, 1976</i>	
<i>(less 11 hospital days) 761</i>	
<i>days @ \$20.00 per day</i>	<i>Cost: \$15,220.00</i>

Currently 72 home health agencies are certified to provide home care services under the Health Insurance Benefits Program. (See map.) Seventy-six percent (76%) of Iowa's population lives in the counties served by these agencies. These 72 agencies primarily provide nursing service and have available at least one additional home care service, such as home health aide, physical therapy, occupational therapy, speech therapy or medical social work.

Screening programs have been added recently to many public health nursing programs. These meet community needs and have the support of

(Please turn to page 58)



The Question Box

by GEORGE G. CAUDILL, M.D.

COMMUNITY SERVICE

Dr. Caudill has completed 11 years of service on the Board of Education of the Des Moines Public Schools. A specialist in the allergies of children, Dr. Caudill comments here on community involvement by physicians plus the problems of education.

You represent one of a number of Iowa physicians who serve their communities in a public service capacity. Why do you do it?

I've always felt that an individual should make a contribution to his community over and above what he might contribute through his profession. Service on the school board is my means of making the contribution.

Are the problems facing public schools, e.g., declining enrollments, limited funds, etc., as grave as many are led to believe?

Under the Iowa plan for funding education, declining enrollment does present a serious problem because the funds districts receive are directly proportionate to the number of students enrolled. With declining enrollment spread over the entire grade structure, K-12, it is difficult to reduce staff members proportionately. Therefore, there is a lag of several years before an economical pupil-teacher ratio can again be established. The financial crunch would not be quite as severe

if it were not for spiraling inflation. The items leading the inflationary list are those most frequently used by school districts, e.g., gas, electricity, paper and books. Also, with declining enrollment we find our buildings are only partially utilized and this is not economical.

Do you believe that physicians have a definite responsibility to become involved in community service of some type?

A frequent criticism levied at physicians is that they do not become involved in community affairs. The excuse too often used is that the pressure of their practice makes it impossible for them to do so. There is, of course, some merit in this argument but I feel physicians should adjust their schedules so they can participate in community activities. Many physicians do serve on school boards; there are other areas also where their services would be valuable.

What one or two health topics are most significant in the provision of education to young people?

Many school systems do not have a structured health education program. This has to be our number one concern. The biggest individual challenge, I feel, in health education is to impress upon the students (as well as the general public) that good health and health habits are essential to a happy, productive life. This includes a philosophy of moderation in the area of food consumption and abstinence in the use of tobacco and drugs.

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Pseudoephedrine
Hydrochloride, NF 30 mg
Alcohol, 1.4%

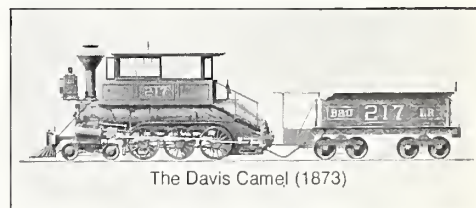
Decongestant action helps control cough and
clear stuffy noses and sinuses. Non narcotic.

Robitussin-CF®

Each 5 ml teaspoonful contains:
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Phenylpropanolamine
Hydrochloride, NF 12.5 mg
Dextromethorphan
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For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The Davis Came! (1873)

A-H-ROBINS

A. H. Robins Company, Richmond, Va. 23220

OUR PHOTO: Norfolk & Western Branch Train
No. 202 west bound near Alvarado, Va. (Oct., 1956).
This line reaches the highest point of any railroad
East of the Rockies (elevation 3,577 ft.) with a
minimum grade of 3%. It crosses 108 bridges,
some 700 ft. long! Photo by O. Winston Link.

IMS VIEWPOINT ON HEALTH SCREENING

THE PAST SEVERAL YEARS persons in various Iowa communities have been invited to participate in one or more mobile multiphasic health testing (MHT) programs. These MHT programs have increased in number nationally in the 1970's. They have as their purpose the gathering of initial health data. Their growth has paralleled somewhat the continuing development of more precise diagnostic and technological equipment.

The Iowa activity (primarily as a service of American Health Profiles, Inc., under local coop sponsorship) has prompted some questions, some concern, some praise, and a need for increased understanding.

The Iowa Medical Society House of Delegates considered MHT programs in 1976. Specifically, the House said the Society should cooperate with these programs when they demonstrate (1) reliability of services and quality control; (2) medical direction by an Iowa-licensed physician; (3) a willingness to seek approval by the local county medical society before operation in the area.

For the benefit of potential screenees and physicians, it may help to quote portions of the American Medical Association policy on this subject:

"Multiphasic health testing (MHT) is one method of initial health data acquisition. It can be performed by automated or non-automated techniques or by a combination of the two. It consists of collecting, recording and reporting test results and, as such, it is an incomplete health service. To be meaningful, provisions must be made to have a physician evaluate and interpret the test results.

"A physician who receives reports from an MHT organization involving persons who have made no prior arrangement with him for their evaluation may choose to accept such persons as his patients, and communicate with them and provide such additional services as are necessary and usual in the physician-patient relationship.

"If the physician elects not to accept the patient, he may return the reports to the MHT organization. If he does so, it is recommended that a covering letter be sent, stating he has not evaluated such reports and the MHT organiza-

tion take the necessary steps to inform the persons tested of the need to make arrangements with a physician for their evaluation and follow-up care if needed.

"It is recommended the physician evaluate any MHT reports involving patients whom he is actively treating or has treated in the past and he communicate with such patients, especially if treatment or further testing is advisable. Failure to do so possibly may result in liability for malpractice if as a consequence the patient is not provided with prompt necessary treatment.

"Even though the person involved is a stranger to the physician, if the testing results for a particular person indicate an urgent and immediate need for medical treatment suggesting a possible emergency situation it is recommended the physician communicate directly with the patient without delay for humanitarian reasons."

MHT has various potential benefits. These include (1) earlier detection of a wider range and a greater number of asymptomatic diseases in apparently healthy people; (2) improved opportunity for preventive care through accumulation of baseline health data; (3) possible reduction in overall health costs due to early detection of diseases, and (4) improved quality control with automated equipment.

Similarly, there is a potential for problems. The limitations include (1) false positives and false negatives on test results; (2) misconception by some that MHT is a complete diagnostic procedure that replaces the need for periodic exams by physicians, and (3) patient apprehension over test abnormalities which may be known to and under treatment by the family physician.

To the one under regular care of a physician, MHT is probably unnecessary. For others, those who have not maintained a regular contact with a physician, MHT may have value. The plea of the Iowa Medical Society, insofar as our State is concerned, is contained in the third paragraph of these comments. In summary, any MHT program should be a quality operation and its presence in any community or county should be known by local physicians prior to its operation.

IN THE PUBLIC INTEREST

Cardiac Valve Replacement With the Glutaraldehyde Preserved Porcine Heterograft

STEVEN J. PHILLIPS, M.D.,
ROBERT H. ZEFF, M.D., and
CHAMNAHN KONGTAHWORN, M.D.
Des Moines

THE GOAL of valve replacement surgery is to implant a hemodynamically acceptable and durable valve, free of thrombo-embolic and infectious complications. Most recent changes in prosthetic valves have been aimed at reducing the incidence of thrombo-embolism. Prolonged effectiveness of these changes has not been demonstrated and anticoagulation continues to be required for the prosthetic valve.^{1, 2, 3} Anticoagulation entails the need for careful patient monitoring and the substantial risk of serious bleeding complications.⁴ As an alternate to prosthetic replacement considerable interest has developed in the use of tissue valve.⁵ One such tissue valve, a heterograft porcine glutaraldehyde preserved valve, has demonstrated a low thrombogenicity rate without anti-

Reported here are valve replacement procedures on 50 patients over a 20-month period. Use has been made of 58 porcine heterograft valves. Satisfactory clinical results have been noted for up to seven years after implantation of the glutaraldehyde preserved porcine aortic valve.

coagulants and long-term hemodynamic durability.⁶

This report, from the Section of Cardiovascular Medicine and Surgery at Mercy Hospital, Des Moines, Iowa describes the result of patients undergoing valve replacement with the glutaraldehyde preserved porcine valve.

MATERIAL AND METHODS

During a 20-month period from January 1975 through August 1976, 58 porcine heterograft valves were implanted in 50 patients. The average age was 50 years (range 16 to 68 years). There were 18 aortic valve replacements, 24 mitral valve replacements, 6 aortic and mitral valve replacements, 1 pulmonic valve replacement, and 1 aortic, mitral and tricuspid valve replacement. Associated coronary artery bypass grafting utilizing the

The authors are in the private practice of cardiac surgery in Des Moines, Iowa, and are associated with the Section on Cardiovascular Medicine and Surgery at Mercy Hospital in Des Moines.

internal mammary artery and/or saphenous vein grafts were associated with 8 aortic valve replacements, and 6 mitral valve replacements. Thirty-eight patients had valve replacements because of chronic rheumatic valvular disease, 6 patients had valve replacements because of ischemic myocardial complications, 3 patients had valve replacements because of Marfan's disease and/or degenerative valvular problems, and three for complications of bacterial endocarditis. Four patients were clinical class II, 30 class III, and 16 class IV, according to the New York Heart Association classification.

Standard techniques of cardiopulmonary bypass with a roller type (Sarns 5000) or pulsatile (Stockert-Cobe) pump, disposable bubble oxygenator, non-blood prime, and mild to moderate whole body hypothermia (30-34°) were used. Aortic crossclamping, and more recently local profound cardiac hypothermia (18-22°C), utilizing cold cardioplegic solution injected directly into the coronary arteries via the aortic root, was used to provide a quiet operative field and myocardial protection. In those patients also requiring coronary artery surgery, bypass grafts were performed prior to replacement of the cardiac valve.

The Hancock (stabilized glutaraldehyde process) porcine Xenograft Valve was used in the majority of cases, and, more recently, the Carpentier-Edwards glutaraldehyde preserved porcine valve with a flexible stent has been used. The average size aortic valve utilized was 25 mm and mitral valve 27 mm. No form of anticoagulation was used in any patient undergoing isolated valve replacement. In patients undergoing combined coronary artery surgery and valve replacement, Aspirin and Persantine were used to enhance graft patency.

Post-operative evaluation and assessment of the patients were obtained by direct patient contact or through the referring physician. No patient has been lost in follow-up. Survival rates and thromboembolic phenomenon were determined.

RESULTS

There were 2 early deaths (4 percent) and 2 late deaths (4 percent). Both early deaths (prior to hospital discharge) occurred in patients undergoing re-replacement of a previously implanted mitral valve. One death occurred due to a technical error at surgery; the second early death occurred on the third post-operative day in a pa-

tient on whom emergency replacement of a clotted Beal valve was carried out. One late death in the mitral valve group occurred in a patient who was on hemodialysis. Emergency surgery was done for acute mitral endocarditis. The patient died suddenly at another hospital while on chronic hemodialysis. There were no early deaths in the aortic valve replacement group and one late death. This death occurred 3 months post-aortic valve replacement from complications of hepatitis. At postmortem examination the implanted valve appeared normal. There have been no mortalities in the patients undergoing double or triple valve replacements (7 patients) or in the group in which combined coronary artery revascularization and valve replacement (14 patients) was carried out. There were no thromboembolic events or complications (0 percent). All patients are presently at class I (32) or class II (18) status.

DISCUSSION

The perfect cardiac prosthetic valve is yet to be developed. The ideal characteristics of a prosthetic cardiac valve include hemodynamic acceptability, lack of thrombogenicity, resistance to infection, long-term durability ease of insertion with a low-operative mortality rate, and ready availability. The cardiac surgeon has at his disposal a variety of mechanical and tissue valve substitutes and is able to replace cardiac valves with a low-operative mortality rate.^{1, 7, 8, 10} Active investigation of various types of valve substitutes has continued because of the dissatisfaction with the thrombogenicity, hydraulic characteristics, mechanical durability, and bulk of the available mechanical prosthesis. A variety of problems, including valve malfunction, cloth and poppet wear, and hemolysis, continue to occur with the most advanced mechanical valve substitutes.^{1, 2, 3} Without anticoagulation, thromboembolism continues to be a major cause of post-operative morbidity and death in patients with mechanical prosthesis.³

The short term clinical results obtained with tissue prosthesis such as fresh or formaldehyde preserved homologous or heterologous aortic valves, fascia lata, pericardium, and dura mata valves have been encouraging from the standpoint of satisfactory hemodynamic function and low thrombogenicity, but in general, the incidence of late post-operative tissue failure in such valves has been prohibitively high.⁵ One composite tissue prosthesis that has provided satisfactory clinical results for periods up to seven

years after implantation is the glutaraldehyde preserved porcine aortic valve mounted on a flexible, dacron, covered stent.⁶⁻¹⁰ This valve is readily available commercially, has excellent hydrolic characteristics, is durable, easy to implant, and has a very low thrombo-embolic rate without anticoagulation.⁷⁻¹⁰

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PERINATAL CONFERENCE

A Conference on Perinatal Medicine will occur March 30 and 31 at the Hilton Inn in Des Moines under the sponsorship of the Statewide Perinatal Care Program, Mead Johnson Laboratories, Ross Laboratories, Maternal and Child Health Division of the State Department of Health, and the Central Iowa Chapter of the National Foundation.

Topics scheduled for consideration include *Pre-natal Diagnosis and Prevention of Genetic Disease, Obstetric Management of Low Birth Weight Infants, Obstetric Anesthesia, Prenatal Gestational Age/Maturity Assessment, Toxemia-Current Management, Obstetric Infections, Maternal-Infant Bonding Process, Neonatal Sepsis, Radiology of the Newborn and Genetic Counseling.*

A principal speaker will be Irwin R. Merkat, M.D., Professor of Obstetrics and Gynecology, Case-Western Reserve School of Medicine, and Director, Cleveland Regional Perinatal Network. Several faculty from the University of Iowa College of Medicine will participate in the program.

Further information may be obtained by contacting the Statewide Perinatal Care Program, Department of Pediatrics, University of Iowa Hospitals, Iowa City, Iowa 52242 (319/356-2637).

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A Comprehensive Insurance Program Is Important!

Advanced Prostatic Cancer Revisited— 35 Years Later

ELIAS JACOBO, M.D., and
DAVID A. CULP, M.D.
Iowa City

The high incidence of prostatic cancer suggests the need for further testing with the available antitumor agents. Even with encouraging results in recent years, survival rates for Stage D carcinoma of the prostate have been the same for 35 years.

IN 1976, 1,100 new cases of prostatic cancer will be diagnosed in Iowa. During the same period the mortality from this disease will be over 350 patients.¹ Approximately 60% of all new patients diagnosed with prostatic cancer will be in advanced stage (stage D) when first seen. Only 50% of these patients presenting with stage D disease will be responsive to hormonal therapy.

Understanding the natural history of a given neoplasm provides the basis for logical treatment. For adenocarcinoma of the prostate, the life history is incompletely defined, particularly (a) in the early clinical stages of the disease and (b) following hormonal therapy. Furthermore, the effect of the patient's age, cellular growth kinetics and variations in the period of time evolved prior to dissemination complicate the disease picture.

Our current staging system has significant limitations (Figure 1). It depicts true clinical staging in a manner which disallows or is different from pathologic staging. The current system does not provide either for the subclassification of the "small" and "large" C lesions or for the stage D's, which have extensive osteoblastic involve-

ment versus the stage D's with only minimal soft tissue or lymph node involvement.

Unfortunately, the improvement in most patients treated with hormonal manipulation and estrogens is temporary and no actual cures have been recorded. At present, the effectiveness of castration—estrogen therapy in disseminated prostatic cancer is measured by certain subjective and objective criteria. Many of these criteria are confusing. For example, serum acid phosphatase levels are normal in over 30% of widespread prostatic cancer. Frequently, we fail to observe lowering of the increased serum acid phosphatase values after castration or administration of estrogens. Increase of previously normal acid phosphatase values has been observed immediately after castration.

When the investigation of hormonal relationship in prostatic adenocarcinoma began, the original working thesis (on which recent hormonal management is based) was postulated by Huggins, namely, that prostatic cancer is an overgrowth of adult prostatic epithelial cells. The belief prevailed that adult prostatic epithelial cells undergo atrophy when androgens are reduced by castration or inactivated by estrogen administration. Wide acceptance of this concept led Huggins and other workers to search for other sources of androgenic stimuli besides the testes. Attention was given to the adrenal gland as the main source of extragonadal androgens in both men and animals. This extragonadal concept of androgenic stimuli motivated many investigators to remove the adrenals in previously castrated patients who continued unresponsive to hormonal manipulation. Despite adrenalectomy and low testosterone levels, widespread dissemination of prostatic cancer continued. With this evidence it was then postulated that certain prostatic cancers were independent of estrogen therapy. More-

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over, recent evidence supports the concept that in the same patient several clones of prostatic cancer cells remain androgen dependent while other clones of cells have undergone de-differentiation and lost their hormonal background, making them insensitive to all forms of hormonal therapy.

The therapeutic concept of orchiectomy and estrogen therapy in the early stage of the disease in otherwise asymptomatic patients was questioned in 1967 by the report of the Veterans Administration Cooperative Urological Research Group (VACUORG). This report indicated early orchiectomy and diethylstilbesterol (D.E.S.) at a dose of 5 mgm per day did not offer better survival than placebo-treated patients.² Furthermore, a retrospective analysis of the VA study reported a high number of cardiovascular deaths in patients treated with DES at a dose of 5 mgm per day.³ Following this report a tendency to reduce the dose of DES to 1 mgm per day was accepted in most U. S. centers. More recently, re-

finement in the technique for measurement of serum plasma testosterone levels utilizing radio-immunoassay methods disclosed that a dose of 1 mgm of DES per day did not adequately suppress serum plasma testosterone levels, whereas a dose of 1 mgm 3 times a day will do so in most cases.^{4, 5}

A better understanding of how testosterone is metabolized and acts in prostatic growth was achieved in 1967 through Bruchovsky⁶ and Wilson's work on the ventral portion of the rat's prostate. It is now clear that testosterone acts as a pre-hormone for its 5-alpha-reductase derivative dihydrotestosterone (DHT) (17B-hydroxy-5-alpha-androstan-1), which is in fact the substance responsible for RNA synthesis at the prostatic nuclei. How this influences prostatic cancer cells and regulates their sensitivity to palliation or other forms of primary clinical treatment remains to be resolved.

It is disappointing after more than 10 years

Classification of Prostatic Cancer by Extent of Lesion

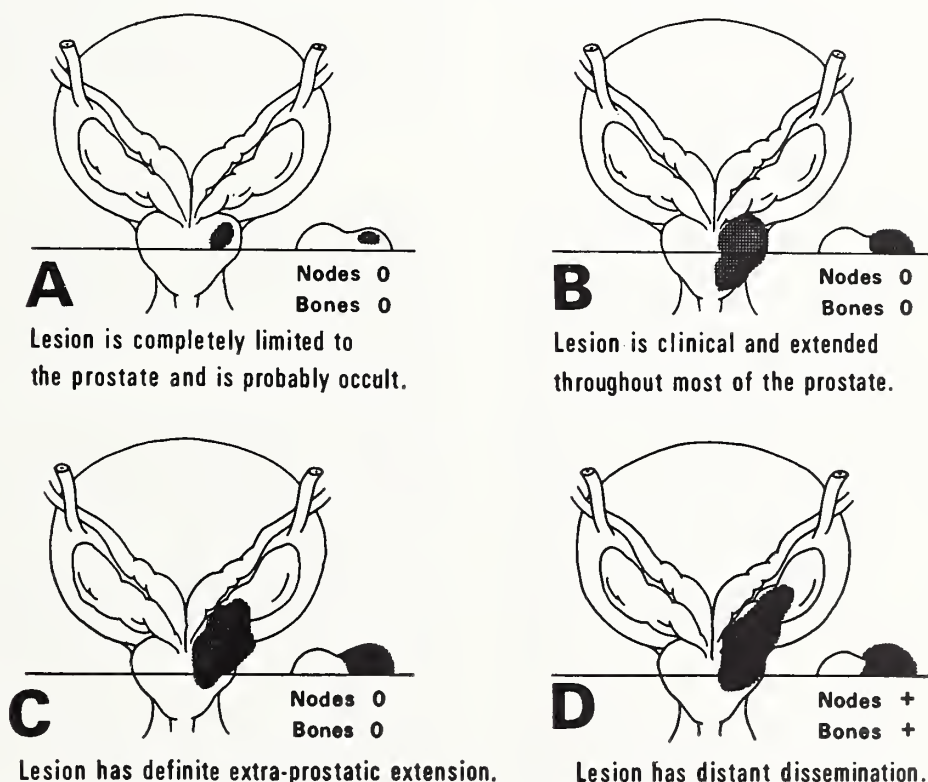


Figure 1. Diagrammatic representation of the currently employed staging system for carcinoma of the prostate. Stage A, lesion confined to microscopic incidental findings usually during transurethral resection. Stage B, lesion confined to one segment of the prostate gland, usually palpable as a small localized nodule. Stage C, lesion invades the seminal vesicles; there is induration throughout the gland. Stage D, spread beyond the prostate gland with lymph node involvement and/or bone metastasis.

since the 5-alpha-reductase activity concept became understood, with its mode of action for protein synthesis in the prostatic nuclei, that it remains unclear as to how this enzymatic machinery intervenes in prostatic cancer. In addition, despite appropriate radiopharmaceutical labeling of target substances incorporated into the prostatic cell nuclei, we have failed to find correlation with androgenic stimulation and prostatic function in aging males.

Regardless of the methods used in hormonal manipulation, it is clear that only 60% of the patients with prostatic cancer will respond to this form of therapy. At the present state of the art it is impossible to predetermine which patient is going to be benefited by hormonal therapy. If the main goal of hormonal therapy in the treatment of prostatic cancer is to suppress the androgenic stimuli to the prostate, this can be achieved by one of the following mechanisms:

1) *Suppression of the pituitary luteinizing hormone release with subsequent inhibition of testosterone production by the Leydig cells of the testis.*

2) *Bilateral orchiectomy.*

3) *Direct inhibition of steroidogenesis.*

4) *Inhibition of androgenic action at the target tissue.*

5) *Adrenalectomy and hypophysectomy.*

HOW ESTROGENS WORK

Estrogens are the most potent inhibitors of gonadotropin secretion and exert their action by suppressing luteinizing hormone release which is the necessary stimulus for testosterone production by the Leydig cells of the testis. Whether estrogens exert an additional inhibitory effect directly on the prostate is a subject of controversy. Experimentally, there is some evidence that high doses of estrogen will inhibit 5-alpha-reductase activity,⁷ the enzyme responsible for the conversion of testosterone to dihydrotestosterone, but the dosage level employed in the experimental animal model is incompatible with human application.

As mentioned previously, 95% of plasma testosterone originates from testicular secretion, and one would expect bilateral orchiectomy to reduce plasma testosterone to low levels. Orchiectomy is considered the most efficacious means to reduce plasma testosterone levels. It does not require the use of additional inhibitory hormones;

the procedure is associated with very low mortality and morbidity rates.

At what stage of the disease should orchiectomy be performed? What are the effects of bilateral orchiectomy in prostatic cancer patients in relation to the plasma testosterone level? These questions are at the present time the subject of multiple controversies. For instance, plasma concentrations of testosterone have been measured in normal men, in patients before treatment for prostatic cancer, and in patients who had various forms of endocrine treatment for prostatic carcinoma. There was no decline in plasma testosterone levels with age.⁸ Patients with non-metastatic disease had levels similar to those of normal controls, but in advanced metastatic disease the levels were low. In patients receiving stilbestrol in doses of 1 mgm 3 times a day plasma testosterone was suppressed at first to negligible amounts irrespective of the clinical response to therapy; subsequently a small but significant rise in plasma testosterone concentrations was observed over a period of six months of estrogen therapy. It is clear from the aforementioned findings that further clinical and experimental work needs to be done to try and elucidate at which point of the disease orchiectomy is indicated and what are the salutary effects of adding oral estrogens to orchiectomized patients.

BLOCKING STEROIDOGENESIS

The recent development of a group of compounds that inhibit the synthesis of androgen in either the testis or the adrenal have attracted attention for use in clinical trials. These agents represent an interesting and promising area for the development of newer agents to treat carcinoma of the prostate.

Aminoglutethimide inhibits the side chain cleavage of cholesterol and subsequent hydroxylation. This agent acts early in the pathway of steroidogenesis blocking synthesis of androgen, cortisol and aldosterone.

Spironolactone acts further down in the pathway and consequently only interferes with the synthesis of androgen. Clinical studies have shown plasma testosterone levels suppressed by 90% with the use of spironolactone. We are now employing this agent in patients with known essential hypertension and carcinoma of the prostate. Since it is in these patients that salt and water retention induced by the use of estrogens has a

(Please turn to page 55)

(Continued from page 54)

major impact upon the cardiovascular system, it is appealing to treat both the hypertension and elevated plasma testosterone levels with one single agent.

Antiandrogen compounds act by inhibiting the formation of the receptor dihydro-testosterone complex suppressing the binding of this complex to the nuclear chromatin and thereby decreasing RNA and protein synthesis. We have utilized in several clinical trials one of these compounds, SCH-13521 (Flutamide), which is a non-progestational non-steroidal agent and neither inhibits gonadotropin nor suppresses plasma testosterone levels. We have found it useful in patients who refuse castration, since the compound acts only at the receptor site without reducing circulating plasma testosterone. Libido and sexual function are preserved and occasionally enhanced. Our clinical experience for the past three years with Flutamide (SCH-13521) reveals that patients obtain a salutary effect for a period of approximately eight months but later on they show progression of the disease.⁹ Conversely, in the same study, we compared in a double blind fashion the efficacy of DES, 1 mgm 3 times a day, and showed no significant advantage of DES over Flutamide. The initial subjective and objective responses were more favorable with Flutamide than with DES.

CHEMOTHERAPY

Well controlled studies investigating the effect of nonhormonal cytotoxic agents in carcinoma of the prostate were lacking until 1973 when the National Prostatic Cancer Project, with five collaborating institutions in the continental United States, investigated in a randomized prospective fashion the effects of chemotherapy (nonhormonal cytotoxic agents) in patients with advanced stage D carcinoma of the prostate who had failed to respond to other forms of conventional hormonal therapy.

The University of Iowa Department of Urology has actively participated in this cooperative study since the early stages of its development. Sev-

eral agents have been evaluated, among others, cyclophosphamide (Cytosan), 5-Fluorouracil (5-FU), estramustine phosphate (Estracyt), Streptozotocin, DTIC and Procarbazine. Results obtained on the first 125 patients employing 5-FU/Cytosan versus standard therapy showed a statistically significant advantage of 5-FU and Cytosan when compared to standard therapy.¹⁰ Standard therapy consisted primarily of estrogen, steroids and Stilphostrol.

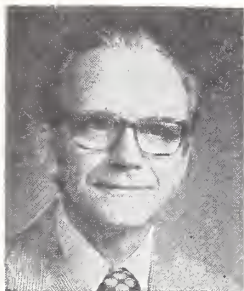
Unfortunately, chemotherapy is often delayed in these patients until there has been such deterioration in the physical and anabolic status that a significant satisfactory response to an efficacious agent would be unlikely. Flocks *et al*,¹¹ in 1968, described the problem stating, "The whole question of the addition of chemotherapy to the armamentarium in management of prostatic cancer needs further intensive study, both early and late in the life history of the lesion."

In spite of the high incidence of prostatic cancer, adequate drug testing in this disease has been neglected. Review of the literature and our own studies on multi-modal therapy in advanced prostatic cancer revealed that only about 12% of the currently available antitumor agents have been adequately tested in prostatic cancer.¹² In contrast, 90% of currently available chemotherapeutic agents have been tested against colon and lung cancer and 35% against testicular cancer.

With the recent encouraging results of the National Prostatic Cancer Project, and through our own experience in the use of chemotherapeutic agents, it is likely this mode of therapy will be placed at a different priority level and used both as single cytotoxic agents and in combination with hormonal therapy in earlier stages of the disease in our constant fight against prostatic adenocarcinoma. The fact that survival rates for stage D carcinoma of the prostate have remained unchanged during the past 35 years invites exploration of new avenues of therapy.

REFERENCES

The references listed in this paper may be obtained on request either from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.



Editorials

M. E. ALBERTS, M.D., Scientific Editor

PRESCRIBING PRACTICES

Physicians must become more aware that prescribing drugs can be one of the trickiest aspects of medical practice. There are many pitfalls which will be heaped upon hazards already inherent in the writing of prescriptions.

The physician must know his patient. Too many individuals seek drugs for ulterior motives. The bona fide patient must be informed of possible side-effects of drugs, the incompatibility of various drugs, the optimal time for ingestion of the medication, as well as the expected benefits. The physician must be aware of the entire content of the "package insert." The nature and action of the drug must be known, as well as the color or shape or vehicle of the drug. But, herein lies a great pitfall. Substitution of a brand-name prescription by a generic equivalent without the informed consent of the physician may lead to confusion on the part of the physician as well as the patient. At a follow-up examination, the question of the effect of "the little red pill" may cause (1) the patient considerable confusion, and (2) the physician embarrassment if the pharmacist has dispensed "large white pills" as a generic equivalent. To avoid such substitution the physician must write "dispense as written" on the prescription.

Before prescribing any drugs it is necessary to ascertain if the patient is taking any drugs, potions or home remedies. Often a simple "over-the-counter" cough syrup, or "cold tablet," or aspirin

is not considered by the patient to be a drug. Explicit questioning must ascertain if the patient is taking any of these, for when taken along with a given prescription there may be incompatibilities or even potentiation of the prescription.

The prescription should be printed or typed in a clear and precise manner. The illegible handwritten prescription has been the object of too many jokes. The risk of misinterpretation by the pharmacist is no joke—at least not by a lawyer. Furthermore, a copy of the prescription affixed to the patient's chart is a wise procedure.

Instructions to the patient must be concise and clear. Definite instructions must be given regarding how long the medicine must be continued, the schedule of the administration of the drug, and what is to be expected from the use of the medication. No longer is there logic in veiling a prescription in mystique. The package should be properly labeled with clear instructions affixed thereon. It is wise to keep to a minimum the number of different drugs that are prescribed, and a definite limitation should be placed upon the right to refill the prescription.

It is imperative that the physician know his materia medica—the drugs he prescribes. Much time, effort and money has been expended to develop the great and wonderful drugs. Consequently, they should not be prescribed in a careless, uninformed or unwise manner. As physicians, we need to apply our maximum expertise in this area. The price of failure is too great.—M.E.A.

GLAUCOMA

The International Glaucoma Congress has been organized recently to strive for the eradication of blindness caused by glaucoma. This group emphasizes the need for early recognition of glaucoma.

It is estimated that eight million Americans suffer from glaucoma, and two to three million of them are unaware that they are so afflicted.

Ophthalmologists often see patients who state that frequent changes in their corrective glasses have been necessary for a year or more, with con-

tinued diminished sight. Many times the repeated examinations have been by a non-medical eye specialist—incomplete examinations consisting of simple refractions only. Then, after painstaking and time-consuming examination by a competent ophthalmologist, the truth is learned—glaucoma has been the cause of the difficulties. Such patients have needlessly lost part of their sight. The loss never can be restored. Glaucoma must be detected early and treated properly to prevent blindness.

Skilled ophthalmologists must perform perimetric tests to find blind spots (scotomata) near the visual center, as well as tonometry and tonography. Another examination consists of measuring the optic disc ratio. In recent years awareness of asymmetry of disc ratios, denoting occurrence of further optic nerve damage, has proved to be a highly reliable sign of glaucoma.

Immediate and long-term control of mild forms of chronic simple glaucoma can be achieved easily with proper miotic drops. As soon as the intraocular pressure is normalized the glaucoma damage ceases. Early diagnosis and treatment are essential to prevent blindness, and these steps can be achieved only by skilled and knowledgeable ophthalmologists.—M.E.A.

COMPUTERIZED TOMOGRAPHY

A medical program on the clinical role of Computerized Tomography will be presented on Sunday, May 8, at the Des Moines Hyatt House. This 9 a.m. meeting is scheduled the day after adjournment of the 1977 Iowa Medical Society House of Delegates and is open to all interested physicians. Further program details will be provided in forthcoming issues of the IMS JOURNAL.

HEALTH PERSONNEL SYSTEM

A Health Personnel Information Services System has been established by the Health Manpower Project/Office for Planning and Programming. Intended to provide an information clearinghouse service, the HPISS will have computer capability and will serve health care providers seeking locations and communities seeking manpower. The IMS Physicians Placement Service will continue its program and will cooperate with HPISS.

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It makes sense now.

STATE DEPARTMENT OF HEALTH

(Continued from page 45)

groups such as medical and dental societies, boards of health, and voluntary health agencies. Some screening clinics are disease-oriented, e.g., diabetes and hypertension. Others are for specific age groups, such as Early and Periodic Screening, Detection and Treatment programs for preschool and school children and screening clinics for the well elderly. Screening is frequently done in connection with other programs such as congregate meals. PHN's have received additional inservice education to assist them with screening techniques. Nursing assessments performed in clinics for children and well elderly are with the support of preceptors and/or medical advisory committees. Patients referred from screening programs are assisted with arrangements for necessary follow-up services. The following summary is that of a rural public health nurse:

Our Early and Periodic Screening Clinic really turned out to be a lifesaver for a 14 year-old girl this month. When screened, she had vague complaints that might lead one to suspect diabetes, and had a familial history of it. Her urine test showed an extremely high sugar content. I was able to get an appointment with her local doctor that day and persuaded the family to go to him. Becky had a very high blood sugar and was admitted to the hospital. She has since been discharged and is fairly well regulated. We will be making regular home visits to her until she is sure of giving her own insulin and of following a proper diet. It only takes one case like that to make you feel that it is worth all the effort involved in screening clinics.

Referrals for public health nursing service come from physicians, hospitals, nursing homes, churches, welfare agencies, schools, relatives, families and patients. Referral systems are improving but a number of people still might more effectively be rehabilitated if the public health nurse knows earlier of their needs. For example,

PHN's find home patients, victims of strokes, who have had no rehabilitative therapy and have been left with deformities. They find mental patients who have had to return to hospitals because their medications have not been monitored at home.

Third party payments have been restrictive in some programs and this has prohibited adequate home care service in many instances. Recent changes in the Title XIX program will make more service available to patients in this categorical group. Increased use of the program will depend on whether the patient comes to the attention of the public health nurse. Referral by the physician is most important.

Even with increased public health nursing staffs and the large volume of services presently performed, community public health nursing needs are not being met. It is estimated in a rural Iowa county of average population, there may be at any one time 100 persons who could benefit by rehabilitative nursing services. This does not count those who need preventive services. It is believed Iowa communities could use at least three times as many PHN's as are now active. Funding is the major problem in providing adequate public health nursing staffs. Federal funding, allocated through the Iowa State Department of Health, assists many local public health nursing programs, and others are financed entirely with local funds. Federal and local funds are not presently available for program expansion. State appropriations are needed to assist local areas in providing additional public health nursing personnel.

Public health nursing has sold itself in Iowa. When additional health funds become available, it is anticipated that counties lacking this service will employ public health nurses. It is also anticipated that more nurses will be added to counties which are presently inadequately staffed. Home care services and preventive services provided by public health nurses may then expand to more nearly meet Iowa needs.—*Thema Luther, R.N., M.P.H., Director, Nursing Section, Community Health Division.*

CONFERENCES FOR MEDICAL PROFESSIONALS

A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialties included. Send a \$10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

Medical Assistants



by BETTY EHLERT, CMA-A

CONVENTION PREVIEW

An outstanding 1977 state meeting is planned at the Sheraton Motor Inn in Mason City, April 15, 16, 17. Richard Caplan, M.D., associate dean for continuing Medical Education, and acting head of the Department of Dermatology, University of Iowa, will speak on "Patient Health and Education"; Robert P. Dinapoli, M.D., neurologist at Mayo Clinic, Rochester, Minnesota, will discuss "Office Neurology." Dr. Dinapoli is a visiting neurologist in Mason City and southern Minnesota clinics; John B. Dixon, M.D., Ophthalmolo-

gist, Mason City, will discuss "What's New in Ophthalmology?" Dr. Dixon has been in India performing cataract surgery on the natives; B. J. Broghammer, M.D., Mason City radiologist, will discuss "New Advances in X-ray Therapy." Dr. Broghammer directed installation of the linear ray therapy machine at Mercy Hospital in Mason City, and Adrian Wolbrink, M.D., Mason City orthopedist, will discuss his medical assignment in Korea. His wife, who was also on this tour of duty, will illustrate life in Korea via song. (The complete program and registration information will appear in the March issue.)

AAMA TO OFFER CE CREDITS

The Continuing Education Committee of the AAMA has announced the beginning of its program for awarding Continuing Education Unit (CEU) credit. This program has been established in response to the tremendous interest in self-improvement on the part of medical assistants in the areas of education and professionalism. Also of considerable bearing are the pressures of increasing malpractice claims, the demand for high-quality health care and government interest in medicine and allied health.

To be considered for CEU credit, a medical assisting educational program must conform to the following criteria:

1. The content of the program must pertain to medical assisting;
2. The program must be at least one hour in length (60 minutes of contact), and must be pre-

sented in an organized, effective learning format;

3. The learning objectives must be defined in *specific* behavioral terms;

4. The instructor(s) must be well-qualified;

5. Participant learning must be assessed; and

6. The program must be evaluated by participants.

Continuing Education Units have been defined as one unit of credit for 10 contact hours. Therefore, for qualified programs, .1 unit is awarded for each contact hour. In order to receive CEU credit, participants must attend at least 80% of the class session(s) and meet the minimum learning requirements established by the instructor.

Program planners wishing to seek CEU credit must submit a completed "Approval Request Form" at least one month in advance of the program being considered. CEU credit cannot be awarded if the program has been held in the past, has already begun, or if academic credit is being awarded.

144 PASS FALL AAMA EXAM

A total of 144 certificates, including 19 from Iowa, was awarded to candidates passing the fall

certification examination given at the 20th Annual Meeting of the American Association of Medical Assistants. The successful candidates represented 21 states.

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Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); and 25 mg phenobarbital in the immediate release layer.

SUSTAINED ACTION

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

See next page for brief summary.



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T-GP-72-B/W

CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral SA: each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

STORE BETWEEN 59° and 86°F (15° and 30°C).

Full information is available on request.

NEW EPILEPSY INFORMATION/ SERVICE CENTER

The Iowa Chapter of the Epilepsy Foundation of America, in cooperation with the Department of Neurology, University of Iowa College of Medicine, has established a new service to epileptic patients, their families and their physicians.

The primary function of this Center is to provide by telephone, personal contact, or by mail, information about services in the following areas:

- a) Employment opportunities for epileptic patients; b) Educational and vocational programs; c) Available insurance; d) Low-cost drugs, and e) Social services and other appropriate community services available in local areas.

The principal operational thrust of the Center will be to inform patients, families and physicians about the many existing services and to make referrals to accommodate patient needs.

Educational materials and other services of the E.F.A. may be solicited from this Center. Publications, tapes, films and slides for both professional and lay audiences are available.

You and your patients are encouraged to use the facilities of this new office which is open during business hours at Westlawn, Box 200, Iowa City, Iowa 52242. The toll-free number is 800-272-6434.

This Center has been made possible by the support of the Iowa Developmental Disabilities office.

MEDICAL MISCELLANY

IMMUNIZATION MATTERS . . . IMS Committee on Maternal and Child Health will meet February 16 with representatives of the State Department of Health to go over current immunization matters and other topics of interest.

EXAMINE MUTUAL PROBLEMS . . . Matters relating to medical practice in hospitals will be examined Saturday, March 12, at a conference for Iowa physicians, hospital board members and hospital administrators. The meeting is a joint project of the IMS and the Iowa Hospital Association and will be at the Hilton Inn in Des Moines. Headlining the program will be James Sammons, M.D., executive vice president of the American Medical Association, and Alex McMahon, president of the American Hospital Association.

Morbidity Report for December

Disease	1976 Dec. 1976	1975 to Date	1975 to Date	Most December Cases Reported From These Counties
Amebiasis	7	57	32	Boone
Brucellosis	—	47	51	
Chickenpox	1060	11908	9507	Scattered
Conjunctivitis	400	2012	1402	Scattered
Erythema infectiosum	8	172	211	Clinton
Gastrointestinal viral inf.	5516	32065	15457	Johnson, Polk
Giardiasis	2	44	30	Boone
Hepatitis				
A (infectious)	5	114	202	Scattered
B (serum)	15	100	93	Scattered
Unspecified	1	23	31	Black Hawk
Impetigo	163	1103	948	Scattered
Infectious mononucleosis	108	1133	1315	Scattered
Influenza-like illness	5299	54193	50790	Scattered
Meningitis, type unspecified	1	9	31	Scott
Meningo- encephalitis	1	3	—	Black Hawk
Mumps	145	1672	1513	Black Hawk

Disease	1976 Dec. 1976	1975 to Date	1975 to Date	Most December Cases Reported From These Counties
Pediculosis	82	876	440	Black Hawk, Cerro Gordo
Pinworms	3	32	42	Johnson, Polk, Scott
Pneumonia	119	1067	1122	Scott
Rabies in animals	7	129	101	Scattered
Rheumatic fever	1	21	14	Lee
Ringworm, body	34	298	333	Scattered
Ringworm, scalp	2	28	11	Appanoose
Rubella (German measles)	12	98	31	Scattered
Rubeola (measles)	69	113	717	Wright
Scabies	269	1135	745	Clinton, Lee, Polk
Streptococcal infections	1347	13715	10357	Linn, Polk, Johnson
Salmonella typhi	1	2	0	Polk
Tuberculosis— total ill	12	123	125	Scattered
Tuberculosis— bact. positive	8	104	88	Scattered
Venereal diseases				
Gonorrhea	452	6493	7194	Linn, Polk, Scott
Syphilis	28	358	309	Polk
<i>Laboratory Virus Diagnosis Without Specified Clinical Syndrome</i>				
Cytomegalovirus 1, Herpes Simplex 4, Herpes Zoster 1				

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■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.

■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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About IOWA Physicians

Dr. Donald G. Flory will join **Drs. C. A. Trueblood** and **L. R. Cornish** in family practice in Indianola on March 1. Dr. Flory received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Broadlawns Hospital in Des Moines. Dr. Flory's twin brother, **Dr. Ronald Flory**, is in family practice in Waterloo. . . . **Dr. Frank Zlatnik**, assistant professor in department of obstetrics and gynecology at U. of I. College of Medicine, and **Dr. Herman A. Hein**, associate professor in department of pediatrics at U. of I. College of Medicine, participated in a recent Sioux City perinatal workshop for physicians and nurses. . . . **Dr. R. H. Mailliard** was recently elected chief of staff of Buena Vista County Hospital. **Dr. K. H. Prescott** was named vice-chief and **Dr. T. E. Shea**, secretary-treasurer. All are Storm Lake physicians. . . . **Dr. Robert C. Miller**, Waterloo, attended a recent seminar on "Coronary and Heart Disease" at Lake Geneva, Wisconsin. . . . **Dr. Richard C. Rogers**, D.O., Eldora, has been elected president of Hardin County Medical Society; **Dr. Joseph Brunkhorst**, Iowa Falls, vice president; and **Dr. Oliver Stotland**, Ackley, secretary-treasurer. . . . **Dr. Kirk Strong** is new president of Jefferson County Medical Society. Other 1977 officers are: **Dr. W. C. Baumann**, vice president; and **Dr. David Ramsey**, secretary-treasurer. . . . **Dr. R. A. Dierwechter**, Storm Lake, has been named a Fellow of International College of Surgeons.

Dr. Robert D. Whinery has been elected president of Mercy Hospital medical staff in Iowa City. Other new officers are—**Dr. O. C. Beasley**, president-elect, and **Dr. P. D. Wallace**, secretary-treasurer. All are Iowa City physicians. . . . **Dr. Theodore Lederman** has joined **Drs. Ronald Roth** and **Ronald Flory** in Waterloo. A Waterloo native, Dr. Lederman received the M.D. degree at U. of I. College of Medicine; interned at Albert Einstein Medical Center in Philadelphia, Pa.; and served his residency in internal medicine at University of Connecticut in Hartford, Conn. Before

locating in Waterloo, Dr. Lederman spent six months with the Department of Community and Ambulatory Care at Mount Sinai Hospital in Hartford. . . . **Dr. Narong Jarasviroj**, a native of Thailand, has joined **Dr. Pat Frankel**, D.O., in family practice in Fontanelle. Dr. Jarasviroj received the M.D. degree in Thailand and completed postgraduate training in surgery at Veterans Hospital and Mercy Hospital in Des Moines. . . . **Dr. E. M. Wittenberg** has been named president of Mary Frances Skiff Memorial Hospital medical staff in Newton; **Dr. J. W. Ferguson**, vice president, and **Dr. K. P. Petersen**, secretary-treasurer. **Dr. T. E. Jessen** is new president of Jasper County Medical Society; **Dr. M. R. Moles**, vice president; and **Dr. T. E. Kiernan**, secretary. All are Newton physicians.

New officers of the Wright County Medical Society are—**Dr. Dale Harding**, Eagle Grove, president; **Dr. S. P. Leinbach**, Belmond, vice president; and **Dr. R. A. Young**, Clarion, secretary-treasurer. Delegates are **Dr. Arthur Benetti**, Belmond, and **Dr. R. A. Young**, Clarion. . . . **Dr. Jose V. G. Angel**, Council Bluffs, is new president of the North Central Region of the American Association for Clinical Immunology and Allergy. . . . **Dr. M. A. Pathan** began a family practice in Dysart in January. Dr. Pathan received his medical education in Pakistan; interned at Mt. Sinai Hospital in New York, and served two years of internal medicine residency at Mt. Sinai and Coney Island Hospital in New York. Prior to locating in Dysart, Dr. Pathan was on emergency room staff at St. Joseph's Hospital in Tawas City, Michigan. . . . **Dr. D. N. Crabb**, Denison, has been named medical staff president at Crawford County Memorial Hospital and president of the Crawford County Medical Society. **Dr. J. M. Hennessey**, Manilla, is vice president; and **Dr. M. U. Broers**, Schleswig, secretary-treasurer. . . . **Dr. Sam Williams**, D.O., Maquoketa, has been named chief of medical staff at Jackson County Public Hospital; **Dr. C. L. Rask**, Maquoketa, vice chief

of staff; and **Dr. J. K. Meyer**, D.O., Maquoketa, secretary-treasurer. . . . **Dr. Curtis Johnson** is new president of Clinton County Medical Society; **Dr. Dale T. Mericle**, vice president; and **Dr. Surendra Kumar**, secretary-treasurer. All are Clinton physicians.

Dr. Paul T. Cawley, Carroll, was named president of Carroll County Medical Society; **Dr. Josef R. Martin**, Carroll, vice president; **Dr. John R. Hornberger**, Manning, secretary-treasurer; **Dr. Homer L. Skinner**, Carroll, delegate and **Dr. J. M. Tierney**, Carroll, alternate delegate. . . . **Dr. William G. Stone**, Waterloo, has received the AMA Physician's Recognition Award. . . . **Dr. Robert Lang**, an Oelwein native, has joined the Ottumwa Clinic in the practice of ophthalmology. Dr. Lang received the M.D. degree at U. of I. College of Medicine; interned at University of Wisconsin Hospitals in Madison, Wisconsin; and served a residency at University Hospitals in Iowa City. . . . **Dr. George Spellman** was named medical staff president at St. Vincent's Hospital in Sioux City; **Dr. M. C. Atash**, vice president, and **Dr. Sidney A. Cohen**, secretary-treasurer. All are Sioux City physicians. . . . **Dr. Dale D. Morgan** was elected president of St. Luke's Methodist Hospital in Cedar Rapids; **Dr. Robert L. Swaney**, vice president and president-elect, and **Dr. James W. Reinertson**, secretary-treasurer. Newly elected chiefs of the medical departments are: **Dr. Leland G. Hawkins**, orthopedics; **Dr. Julianne H. Thomas**, pediatrics; **Dr. Dennis L. Boatman**, surgery; **Dr. Saturnino S. Ortega**, psychiatry; and **Dr. Larry D. Helvey**, emergency. Department chiefs re-elected to their posts are: **Dr. Mark J. Tyler**, family practice;

Dr. Richard M. Quetsch, medicine; **Dr. William A. Davis**, obstetrics and gynecology; **Dr. John Huston, Jr.**, radiology; **Dr. Merlin G. Osborn**, anesthesiology; **Dr. Kingsley B. Grant**, pathology; and **Dr. Donald D. Weir**, rehabilitation.

DEATHS

Dr. Paul L. Gjerstad, 36, Maquoketa, died December 7 at Mercy Medical Center in Dubuque. Dr. Gjerstad received the M.D. degree at U. of I. College of Medicine and had practiced in Maquoketa for six years. He was a member of the Jackson County Board of Health and former chief of staff of Jackson County Public Hospital.

Dr. John B. Thielen, 67, Fonda, died at his home December 1. Dr. Thielen received the M.D. degree at U. of I. College of Medicine; interned at Mary's Help Hospital in San Francisco, California. He began his private practice of medicine in San Francisco and located in Fonda in 1945. He served as mayor of Fonda from 1956 to 1960 and in 1970 was named honorary chairman of Fonda Centennial Celebration. Pope John XXIII named Dr. Thielen a Knight of St. Gregory, highest honor bestowed upon a layman by the Catholic Church.

Dr. Frank J. Piekenbrock, 80, Dubuque physician and psychiatrist for 51 years, died December 19 at Mercy Medical Center in Dubuque. Dr. Piekenbrock was a founder of Medical Associates in Dubuque. He was a member of Iowa and American Psychiatric Associations; Fellow of American College of Physicians; member of American Board of Internal Medical Specialists; and life member of Iowa Medical Society.

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RECENT CHANGES

federal register

HIGHLIGHTS

Providing Drug Information to Physicians

Informational Bulletin #433-76

National Health Insurance

special report
Malpractice insurance:

drug bulletin

Health care doesn't need more red tape

Drug firms challenge 'MAC' rules

Drug Substitution

RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
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OBSTETRICIAN-GYNECOLOGIST wanted to join two-man department in established 19-man multi-specialty group in Central Iowa. Immediate financial partnership. Outstanding fringe benefits. Regional hospital, excellent schools, recreational facilities. Write No. 1519, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

CARDIOLOGIST, UROLOGIST, ORTHOPEDIC SURGEON, and OPHTHALMOLOGIST wanted to join established 19-man multi-specialty group in Central Iowa. Immediate full financial partnership and outstanding benefits. Progressive community with regional hospital, excellent schools, and recreational facilities. Write No. 1520, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

OBSTETRICIAN-GYNECOLOGIST wanted by 15-man multi-specialty clinic. Good facilities. Medical school affiliation, if desired. New hospitals. Guarantees \$50-60,000 first year. Partnership thereafter. Write No. 1521, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

FREE OFFICE EQUIPMENT—for physician willing to assume family practice in eastern Iowa city located on beautiful Mississippi River. For additional information call or write John Tilton, M.D., Bellevue, Iowa 52031. 319/872-4241.

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'77 SCIENTIFIC SESSION

Interest in and speculation over federal health care policies and programs are at a high level with the new administration in place. An expert evaluation of this subject will be a highlight of the 1977 IMS Scientific Session at Telemark Lodge in Cable, Wisconsin.



Marjorie Lynch, Undersecretary of Health, Education and Welfare in the Ford administration, will be at the IMS Scientific Session to discuss the major national health care issues and offer her predictions. Mrs. Lynch's address is scheduled on Thursday, July 14.

This 1977 continuing medical education event of the Iowa Medical Society will occur July 12, 13 and 14 in Cable, Wisconsin. A variety of scientific topics are on the program, including cardiology, endocrinology, caring for the pulmonary cripple, infectious diseases, scope of family practice, even a speech training seminar.

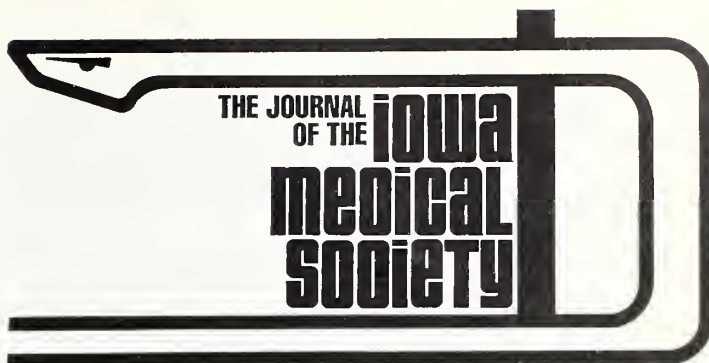
Reservations for the session are being received and the limited accommodations are being assigned on a first-come basis. Please contact IMS Headquarters for more info and registration forms.

HOUSE OF DELEGATES

Closer on the 1977 schedule is the annual session of the Iowa Medical Society House of Delegates. This meeting will be May 6 and 7 at the Hyatt House in Des Moines. Early resolutions have been received from Cerro Gordo and Black Hawk county medical societies. Other counties planning to submit resolutions are urged to do so as soon as possible.

Richard E. Palmer, M.D., Alexandria, Va., President of the American Medical Association, will be in Des Moines to address the delegates.

Activities related to the House of Delegates session are in process. The Delegates' Handbook, which contains committee reports and resolutions received, will be distributed in late March. In addition, the 1977 IMS Nominating Committee will meet March 27 at Society Headquarters to develop a slate of officers.



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President's Page



As we ponder the steady encroachment of the federal government into health care, we are prone to ignore a staunch ally whom we are in danger of alienating—the business and industrial community.

Over the past several decades, interesting things have come to pass by a process which might be termed "Private Enterprise Socialism." Aside from increased wages and salaries, a vast array of so-called social benefits have accrued to a majority of the population: paid vacations and holidays, pension plans for retirement, life insurance, sick benefits when ill or injured, medical and hospital care paid for in full, with the list still growing. In so-called socialistic countries, these goodies are awarded to the population and paid for by funds from taxation. In this country, the costs are, in large measure, also paid for by the citizenry but through increased prices for goods and services. The benefits are arrived at by good, hard American bargaining. The prices the citizens pay are determined by firm business judgement and competition. This kind of socialism is far preferable, it seems to me, to that imposed by rigid government control and stifling bureaucracy.

However, our allies grow restive under the steadily increasing costs of health care which they have assumed and they seek some relief. This is understandable when we learn that General Motors paid more to Blue Cross-Blue Shield for its employees' insurance in 1975 than to U. S. Steel for metal for its cars.

We can help them contain the rising expense by ordering only those hospital days, x-rays, lab tests, and ancillary services necessary for good care. We can keep sick benefits to a reasonable level by returning people to work when ready. We can show restraint in raising fees. Without such help, our allies may tell their people to seek out relief from their health care costs wherever they can find it. The Kennedy-Corman-Labor bill waits with unblushing eagerness in the wings.

James F. Bishop, M.D.

James F. Bishop, M.D., President

IOWA Medical Miscellany

NEW LEGISLATIVE APPROACH . . . Iowa legislators devoted much of February to committee deliberations under new format intended to speed the 1977 Assembly. Floor debate is intended to move more swiftly with committee considerations completed. Various medically-related items are on the Assembly line.

ISSUES OF INTEREST . . . As this is prepared, it's still speculative which health delivery proposals will be given formal consideration by the 1977 Assembly. The House Commerce Committee has approved a professional liability bill which contains several IMS-supported provisions (periodic payments, arbitration, etc.). Moves to broaden both the optometric and chiropractic practice acts are in process with the Society registering opposition to both. Radiation control legislation is being pursued in several forms with IMS input having been provided. Certificate of need legislation, which is federally required within the next several years, is in the development stage. The Society is seeking to exclude physicians' offices from any such bill. Among other health propositions in an introductory status are bills (1) to make immunization of children for communicable diseases mandatory, and (2) to modify Iowa's corporate practice rule to allow hospital and institutional employment of physicians for purposes of selling their services.

INSURANCE MATTER . . . Insurance Commissioner Herb Anderson has ruled St. Paul Fire and Marine erred in some premium determination during parts of 1975 and 1976. Affected are various Iowa hospitals carrying St. Paul liability insurance. St. Paul has agreed to refund the overcharges.

HANDBOOK DISTRIBUTION . . . The 1977 Handbook for the House of Delegates will be distributed in late March. The Handbook contains committee reports and other material for delegate review in advance of the May meeting.

TESTIFY . . . Donald Young, M.D., and Clarence Denser, Jr., M.D., testified for the Society during February before the Joint Human Resources Committee and the Senate Commerce Committee, respectively. Dr. Young explained the IMS stance on certificate of need legislation, and Dr. Denser covered the professional liability situation.

APPROVE MEDICAID SUPPLEMENT . . . An \$8 million supplement to the Iowa Medicaid program has been okayed by the House of Representatives. This sum is needed to keep the program afloat for the remainder of the fiscal year. The State Department of Social Services had requested \$9 million to maintain the program until July 1. For the coming fiscal year askings range from \$74 million by the Governor to \$84 million by the SDSS.

ELECTED . . . John Tyrrell, M.D., Manchester, was elected in February as vice-chairman of the Iowa Statewide Health Coordinating Council (SHCC). Dr. Tyrrell serves on the SHCC as a consequence of his provider representation on the Iowa Health Systems Agency (HSA). The 31-member SHCC is advisory to the State Health Planning and Development Agency (SHPDA). It has responsibility for reviewing the state health plan and various other planning duties.

NOMINATING COMMITTEE . . . The 1977 IMS Nominating Committee will meet Sunday, March 27, at Society headquarters. Representatives to the Nominating Committee have been selected in district caucuses. The committee will prepare a slate of candidates for consideration by the House of Delegates in May.

RESOLUTIONS . . . County medical societies wishing to submit resolutions to the 1977 IMS House of Delegates should be mindful of the need to forward them to IMS headquarters as early as possible. Those received in time are printed in the Delegates' Handbook, others are duplicated and placed in the Delegates' Packets.

IMS-Sponsored Liability Program Begins

The Iowa Medical Society-sponsored professional liability insurance program offered by Aetna Life and Casualty will become officially operative March 15, 1977. Sponsorship was authorized January 27 by the IMS Executive Council on recommendation of the Medico-Legal Committee.

The January recommendation and the resulting Council action are based on direction from the IMS House of Delegates. The following House resolution was approved May 2, 1976:

"Resolved, That the Society maintain its active liaison with the insurance industry and pursue with any reputable company the possibility of a Society-sponsored, group type coverage, with any such program to be presented for approval either to the Executive Council or the House of Delegates."

Under the IMS/Aetna program, interested member physicians may voluntarily apply for the package coverage which has three required parts: 1) primary professional liability, 2) office prem-

- Coverage is on the traditional occurrence form, as opposed to the claims-made form.

- The primary professional liability component is \$100,000/\$300,000 for physicians in the lower classifications and \$250,000/\$500,000 for those in the higher categories.

- The catastrophe insurance will be required at a minimum of \$1 million with higher increments available. This will cover personal and professional exposures subject to certain requirements.

- A key phase of the program will involve a full-time Aetna coordinator working with the Society to evaluate liability claims and promote loss control. Physician-review mechanisms will be used to assess the merits of any claims and recommend action.

CLAIMS-MADE ENDORSEMENT

Any IMS member holding a claims-made policy and planning to enter the Society's new liability program is strongly urged to arrange for purchase of the reporting endorsement or tail. Such action assures coverage in perpetuity for incidents occurring in the period for which the claims-made policy was active.

ises liability, and 3) catastrophe (frequently referred to as excess or umbrella) coverage.

Informational material, including a covering letter from Society President James F. Bishop, M.D., is being mailed to IMS members. In addition, briefings are planned at various county medical society meetings during the coming several months. Specific inquiries about the program may be directed to IMS Headquarters.

Following are several key provisions of the IMS/Aetna program:

- Appeal privileges will be available to any physician for whom coverage is denied or for whom a claim is believed to have been improperly handled.

- Full disclosure will be made to the IMS as to premiums collected, claims paid, etc. Program experience in Iowa will dictate future rates and overall success of program.

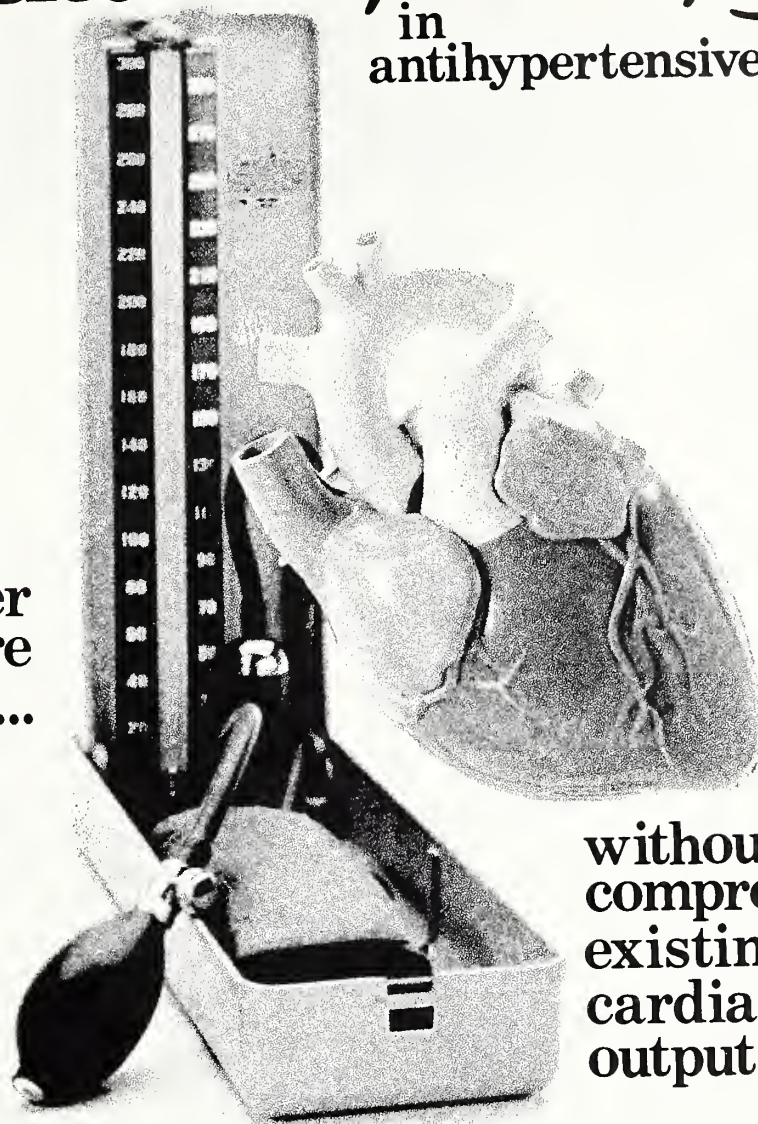
- The premiums will be competitive and will have manual rates as their basis. The program will follow a cost-plus approach with a dividend plan in effect if successful experience is achieved.

- The coverage is guaranteed by Aetna (for an initial period of three years) and policies will have a common anniversary date of February 1. The coverage will be provided through local Aetna agents.

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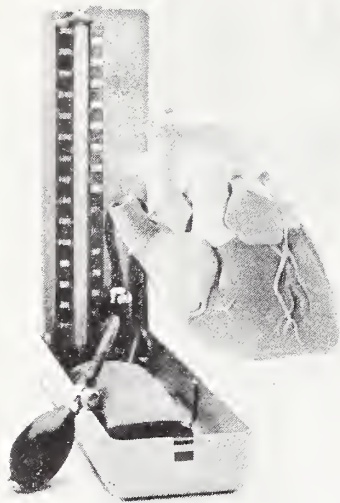
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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (707)

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Educationally Speaking

by RICHARD M. CAPLAN, M.D.

MEDICAL WRITING— A BOON AND A BLIGHT TO CONTINUING MEDICAL EDUCATION

Medical Writing—where would we be without it! We'd all quickly agree, wouldn't we, that our forward progress in medical matters, and most everything else, would shortly come to a halt if we had available only verbal communication. After all, verbal interchanges are so full of non-fluencies and jibberish: "My last remark relative to that subject and in terms of the parameters or value systems we commonly use, is intended to mean . . . , well, that is, if you don't mind my changing the subject, uhh, the cost-benefit analysis will surely optimize the data and impact with all the other interfaces of our current perspectives . . . blah, blah, blah." Sentences like that last one are easy to generate in *speech* without half trying. They must be; we hear them so often. But it's really work to *write* such a monstrosity. And in writing we have the vital advantage of being able to edit, and edit again.

Some people (naive, misguided babes!) think

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

that good writers produce their product more easily than less facile writers. Yet the testimony from fine writers tells us, with almost no dissenting voice, that they work the hardest of all at the craft of writing. Fancy the orgy of creativity needed to fashion this alliterative gem: Interval interpretation, initially, is incredibly inspiring in its inexorable ineptness. Or: Malpractice among multiple manipulators may magnify malevolent maelstroms. I promise you such beauties don't blossom fully formed like Pallas Athena from the forehead of Zeus. They require an agony like delivering a nine-pound footling breech from a primip.

And what has this to do with Continuing Medical Education? This—medical writing that is complex, fuzzy, ambiguous, soggy or overlong not only impedes our grasping *its* message, but over the years stunts our willingness to keep on reading. As we decrease our practice in reading the medical literature, our reading skill and desire atrophy. The prognosis for satisfactory rehabilitation of an atrophied medical reader is bleak.

So if you are a writer, or editor, work hard at your words before you publish. And if you're a reader, but weakening, remember: KEEP AT IT! ILLEGITIMITAS NON CARBORUNDUM!*

* Translation will be gladly provided upon request, along with other ribaldries.

MEDICAL MISCELLANY

IFMC ELECTS . . . John H. Brinkman, M.D., Mason City, was named president of the Iowa Foundation for Medical Care at the IFMC annual meeting February 9. Other officers are R. H. Westfall, M.D., Council Bluffs, first vice-president; R. B. Anderson, D.O., Davenport, second vice-president; T. F. Dynes, M.D., Decorah, secretary, and J. H. Sunderbruch, M.D., Davenport, treasurer.

TOP SPOKESMEN . . . James Sammons, M.D., executive vice-president of the AMA, and J. Alexander McMahon, president of the American Hospital Association, will headline a March 12 conference on matters of mutual importance to physicians, hospital administrators and hospital trustees. The conference will be at the Hilton Inn in Des Moines and is a joint project of the IMS and the Iowa Hospital Association. Any interested IMS member may attend.

bite back

Taxes can and usually do eat up large portions of the successful professional person's income. And, being successful, you are also probably too busy to do much about it. There is, however, a simple and easy way for you to bite back at taxation. Turn your financial problems over to the Trust Department of your Iowa bank. We understand the investment needs of professional people and can plan your investments to mitigate the effects of taxes. And, with an Investment Management Account or Living Trust we will handle all the detail work: bookkeeping, tax information and all the decisions involved in maintaining a sound investment program. To make it even better for you, our fee is tax deductible. So why try to be a do-it-yourself investment manager when your bank has a whole department of skilled and experienced people to do it for you? Iowa Trust Departments can save you time and money. Find out how . . . soon.



Form 1040 US Department of the Treasury Individual Income Tax Return

For the year January 1–December 31, 1971, or other taxable year

Place label on form you file.
Correct name, etc., if necessary.
Enter social security number(s) if incorrect or shown on label.

Name (If joint return, give first names and initials)
John Q. and Jane

Present home address (Number and street, including apartment or room number)
1776 Liberty Drive

City, town or post office, State and ZIP code
Hometown, Iowa 501

Filing Status—check only one:

- 1 ☐ Single
2 ☒ Married filing jointly (even if only one had income)

Schedules A&B—Itemized Deductions and Dividend and Capital Gains

Department of the Treasury
Internal Revenue Service

▶ Attach to Form 1040

Name(s) as shown on Form 1040

John Q. and Jane D. Public

Schedule A Itemized

SCHEDULE C Profit (or Loss) from Business

Department of the Treasury
Internal Revenue Service

▶ Attach to Form 1040.
▶ Partnerships, joint venture:

Name(s) as shown on Form 1040

John Q. and Jane D. Public

A Principal business activity.
(See Schedule C Instructions)

(For

SCHEDULE D Capital Gains and Losses

Department of the Treasury
Internal Revenue Service

▶ Attach to Form 1040. ▶ E
gains and losses on stocks, bonds, and other personal assets such as a

Name(s) as shown on Form 1040

John Q. and Jane D. Public

Part I Short-term Capital Gains and Losses

b. How

Form 4136

Department of the Treasury
Internal Revenue Service

Computation of Gasoline, Special Fuel, and Other Tax Credits

Attach this form to your

or other taxable year beginning —

(as shown on page 1 of your income tax return)

John Q. and Jane D. Public

Part I

Gasoline
and Special



SCIENTIFIC ARTICLES

Reconstruction in Head and Neck Cancer Patients

CHARLES J. KRAUSE, M.D.

Iowa City

Functional and cosmetic reconstruction of the head and neck cancer patient must be the surgeon's goal. The author declares this is no less important than complete ablation of tumor.

DEVELOPMENT OF IMPROVED RECONSTRUCTIVE TECHNIQUES has closely paralleled advances in the treatment of head and neck cancer. In years past, many surgeons were reluctant to subject a patient to an extensive resection because of the severe deformity which inevitably resulted. As our ability to restore such a patient functionally and cosmetically has improved, we have been able to be more aggressive in our approach to the cancer, and to combine a surgical attack with radiation therapy or chemotherapy. Today, immediate reconstruction is an essential principle of head and neck oncology.

No group of patients more dramatically illustrates the importance of this principle than

Dr. Krause is a professor and vice chairman in department of otolaryngology and maxillofacial surgery at University of Iowa College of Medicine.

those with carcinoma of the oral cavity. Without reconstruction, such a patient may be unable to swallow food or saliva, or even speak intelligibly. There can be no justification today of allowing a patient to remain in such an unfortunate state.

Reconstruction of the oral cavity may require merely primary closure of the defect, or may involve a complex interaction of multiple tissue flaps and grafts. The surgeon must carefully map out his approach before beginning, and then proceed immediately to the reconstructive phase after ablation of tumor is complete. To do this he must possess a thorough knowledge of reconstructive principles.

PRIMARY CLOSURE

Following removal of an oral lesion, simple approximation of the defect margins is frequently possible. However, when sizable defects are closed in this manner, mobility of the tongue in speaking and eating may be unduly restricted. Following are some general guidelines which have resulted in better functional restoration of our patients.

1. When the mandible is left intact, a flap should be used to close the defect if the resection involves more than one centimeter of tongue width along with the entire floor of mouth.

2. When the angle and ascending ramus of the

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS
THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MARCH 1977.

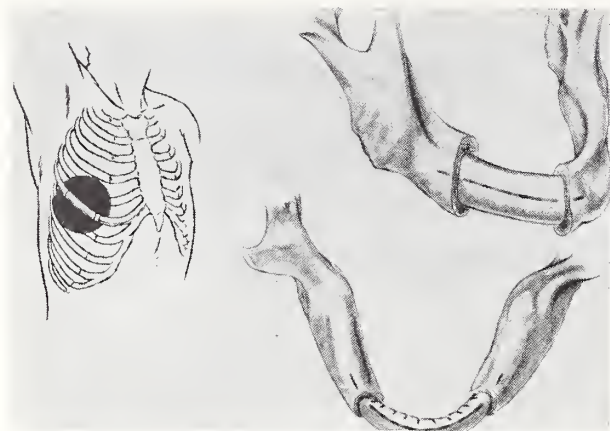


Figure 1a. Mandibular reconstruction with rib graft.



Figure 1b. Mandibular reconstruction with iliac bone graft.

mandible have been removed, a flap should be used if the resection margin extends medially further than the midline of the tongue or above the apex of the tonsillar fossa.

3. The tongue itself may be utilized for local flaps to close defects. The donor site is then closed primarily, and usually results in little if any functional impairment.

4. When a patient has inadequate tongue mobility after six months, a tongue release should be done. This is accomplished by surgically freeing the tongue from the cheek, then covering the raw surface with a split thickness skin graft.

GRAFTS

Autogenous skin and dermis grafts are frequently used to cover mucosal defects in the oral cavity, and bone grafts are useful in restoring mandibular contour.

Skin Grafts:

Free skin grafts may be of varying thickness depending upon the thickness of underlying dermis included. Thin split thickness grafts "take" readily and are useful in covering superficial oral defects. Full thickness grafts are more desirable to cover external defects of the face since the color and texture more nearly approximate the surrounding skin. So coupling and later ingrowth of vessels from the recipient site into the graft is possible, fluid must be prevented from collecting beneath the graft. This may be accomplished by placing a pressure dressing over the graft, or by frequent evacuation of accumulated serum from beneath the graft.

Dermis Grafts:

A dermis graft consists of a free graft of skin

from which the epidermis has been removed, leaving the epidermal appendages in place and exposing the rich subpapillary capillary network. These grafts may be used within the oral cavity to cover epithelial defects or may be buried beneath skin. When a dermis graft remains buried, the epithelial elements gradually atrophy.

Bone Grafts:

Autogenous bone remains the most successful material for use in mandibular reconstruction.¹ Many types of synthetic material have been tried, but all have met with limited success. Mandibular reconstruction is best accomplished with the use of cortical and cancellous bone wired into position and stabilized until healing has occurred (Figure 1a). Though rib grafts are easily obtained and readily shaped, the cortical bone is frequently very thin, and may result in an unstable graft (Figure 1b). The use of bone from the iliac crest is more satisfactory, particularly in replacing anterior mandibular defects. When the oral cavity has been irradiated, it is necessary to place a flap of non-irradiated tissue into the oral cavity to surround the graft.

FLAPS

A flap consists of a portion of skin and underlying subcutaneous tissue which is transferred from one site to another, retaining its vascular attachment to the body at all times during the transfer. The free flap represents a variation of this, in which the feeding vessels to the flap are transected and then reconstituted by anastomosing them to vessels of similar size at the recipient site. This allows the transfer of a greater bulk of tissue than would be possible with a free graft, or transfer to an area of impaired circulation.

Local Flaps:

A flap transferred to an adjacent area is called a local flap. The design of these flaps when used about the face may be varied and complex. Some general principles should be followed:

1. Always begin the flap design at the defect, and measure backward to the donor site. Thus one may be assured the flap will be of sufficient width and length to cover the defect.

2. The length to width ratio should be approximately 2:1 in most instances. Though with axial flaps this ratio may frequently be exceeded, it remains a time honored concept which most consistently provides satisfactory results.

3. Always select a suitable donor site. Color, texture, and presence of hair are important considerations. In addition, the transfer of a flap always results in a defect. One must be certain the donor site may be more readily closed, or the presence of a free graft here be more acceptable cosmetically and functionally than at the recipient site.

4. Never trim a redundant area of pedicle at the time of transfer. When such a "dog ear" is trimmed, the pedicle may be narrowed and necrosis ensue. The excess tissue may be readily trimmed after neovascularity is well established.

Regional Flaps:

A regional flap is one which originates in an area close to, but not adjacent to the defect.

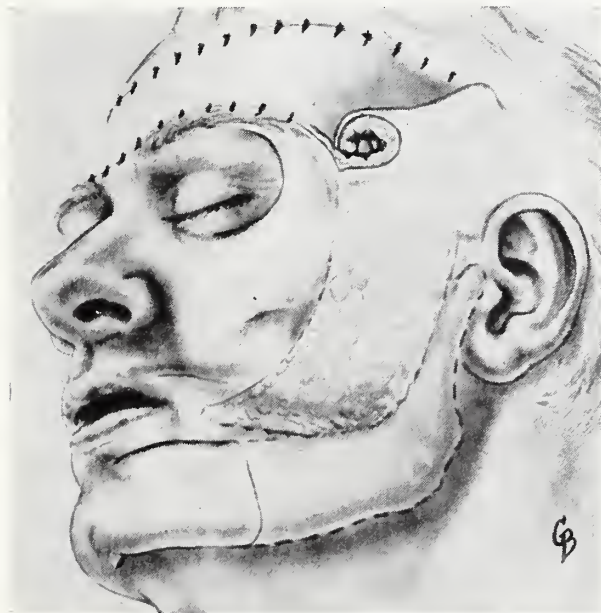


Figure 2b. Intraoral use of the forehead flap. Access over zygomatic arch.

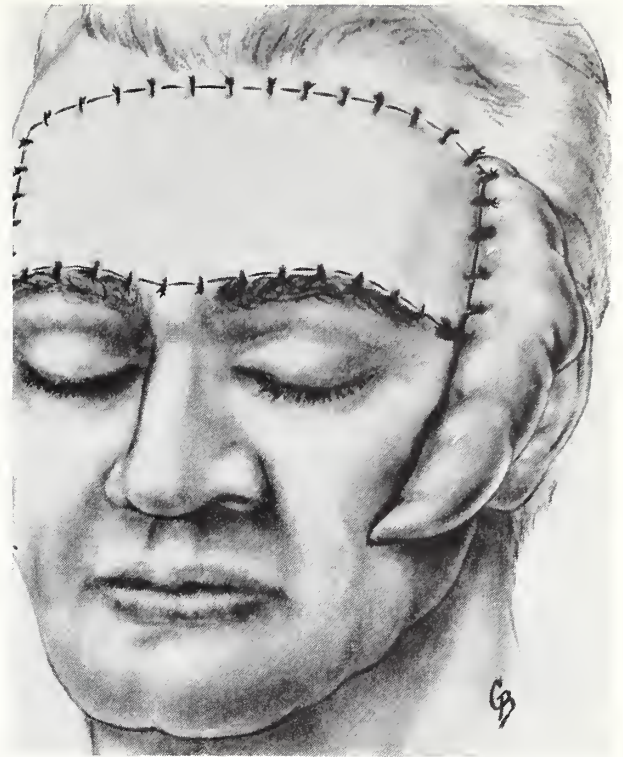


Figure 2a. Intraoral use of the forehead flap. Access through cheek.

Much of the recent advancement in head and neck reconstruction is due to the development and widespread use of regional flaps. In most instances, axial circulation is present in at least a portion of the flap and it is possible to transfer it without delay. This allows reconstruction to begin at the time of surgical resection. Though a number of regional flaps have been described, two of the most useful in head and neck reconstruction will be discussed.

Forehead Flap—A forehead flap based upon the superficial temporal artery offers a large area of non hair bearing skin which may be readily used within the oral cavity and need not be delayed.² In most instances the forehead is outside standard radiation fields to the oral cavity, so the flap represents non-irradiated tissue.

The forehead flap may be placed within the oral cavity in several ways. A simple method of entry is via a cheek incision paralleling facial nerve branches (Figure 2a). Though this method offers rapid access to the anterior mouth, one sacrifices a bit of usable flap length, and placement for defects posteriorly in the mouth may be awkward.

The flap may be turned on itself and brought

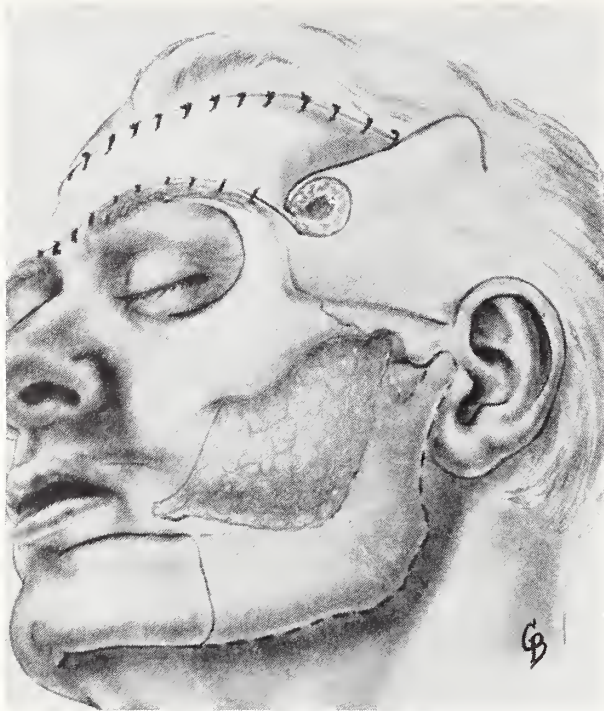


Figure 2c. Intraoral use of the forehead flap. Access behind zygomatic arch.

over the zygomatic arch and into the mouth through buccal mucosa (Figure 2b). When this route is chosen, it is important to avoid injury to the zygomatic branch of the facial nerve and to be certain that an adequate opening is made through the cervical fascia as it attaches to the zygomatic arch. With the flap in place within the mouth, the pocket should admit two fingers along with the flap.

A third method involves entry through the gingivobuccal sulcus from behind the zygomatic arch (Figure 2c). This method is best used when the ascending ramus and condyle of the mandible have been removed. Even then the space behind the zygomatic arch may be small, requiring out-fracturing of the arch or resection of a portion of the temporalis muscle.

The donor site is covered with a split thickness skin graft. Three weeks later the pedicle is transected within the mouth and the pedicle returned to cover the temporal area. Several techniques may be used to improve the cosmetic appearance of the donor site:

1. Leave the frontalis muscle in place when elevating the flap.
2. Bevel the peripheral incisions.
3. Cover the defect with thick split thickness skin; i.e., 0.018-0.020 inch.

4. Return only enough pedicle to make the forehead defect symmetrical. A symmetrical forehead defect is much more acceptable cosmetically than one involving only half the forehead width.

Deltopectoral Flap—The deltopectoral flap as described by Bakamjian,³ is based upon three perforating branches of the internal mammary artery (Figure 3). When designed in a ratio of no more than 2.5:1, it may be used non-delayed. When greater length is required or when one desires a greater width at the end than at the base, delay of the flap is advisable.

The flap may be brought inside the mouth through a submandibular incision or used for external defects. The pedicle is tubed and the donor site covered with a thick split thickness skin graft. Three weeks later the pedicle may be divided and returned to the chest. When the defect is large, bilateral deltopectoral flaps may be used simultaneously.

Distant Cutaneous Flaps:

The use of regional flaps in head and neck reconstruction has largely replaced the use of more distant flaps. The classical thoracic or abdominal flaps which must be elevated, tubed, and "walked

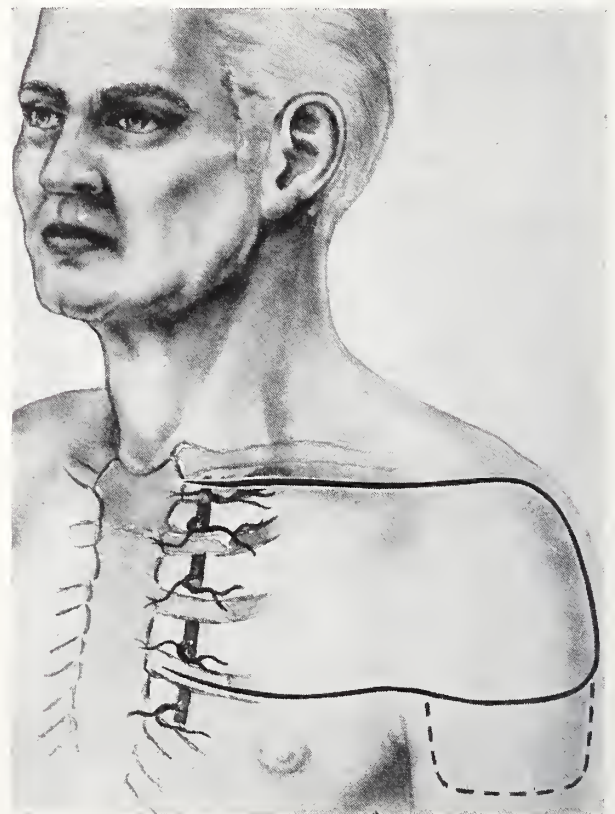


Figure 3. Deltopectoral flap illustrating extension down onto upper arm.

and/or carried" to the head in numerous steps involving considerable delay are almost never necessary today. In most instances, regional flaps offer the surgeon a great deal more flexibility and require much less hospital time for the patient.

Free Flaps:

Development of effective methods for anastomosing vessels of 1-2 mm diameter has resulted in the successful use of free flaps in reconstruction. After the flap of skin and subcutaneous tissue is completely excised to include its feeding vessels, it is sutured into the defect and the vessels are anastomosed to similar sized vessels at the recipient site. This method allows flaps to be transferred to distant sites in a single stage, and results in immediate high volume flow in the recipient area. Though a number of possible donor sites have been identified, the groin area as described by McGregor and Daniel remains the most commonly utilized.^{4, 5} Recently we have reported the successful utilization of free groin flaps for intraoral defects.⁶

SUMMARY

General principles of reconstruction relating to the head and neck have been discussed. Primary closure may suffice when the surgical defect is small, but larger defects require the use of regional flaps to restore adequate function. Skin and dermis grafts are used to cover superficial defects, and bone grafts to restore the mandibular arch. Early restoration of function and appearance must be the surgeon's goal—no less important than complete ablation of tumor.

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Iowa Cancer Diagnosis 1973-74

JOHN W. BERG, M.D. and
Y. CHANG, B.S.
Iowa City

This is another in a series of brief statistical reports on cancer in Iowa. Emphasis is placed on the need for improvement in diagnosis of stomach and pancreatic cancers.

COMPARED WITH 1970-1971 data from the End Results Group,¹ the favorable stage figures reported earlier for Iowa breast and cervical cancers are not a general finding.

The darkest spot involves the most common cancer. Nationally, 44% of all bowel cancers were found while still localized to the bowel wall. In Iowa, only 32% of the tumors were in this early stage. Prostatic cancer presentation was slightly better than expected, lung cancer slightly worse. Only breast cancer, of these 4 most common cancers continued to be detected at a significantly earlier stage than expected.

Of the other major cancers, stomach and pancreatic cancers, just as bowel cancer, were less often localized than the national figures would predict. Endometrial cancer was localized somewhat more often, cervix cancer substantially so. Bladder cancer was seen slightly earlier; ovarian and kidney cancer at almost the identical stage as ERG reported. The one particularly heartening area, besides the breast and cervical cancer results, was that laryngeal and oral cancers were found when localized substantially more often than in the ERG series. It would appear that Iowans have relatively early detection of those cancers that can be found by inspection or super-

ficial palpation. Otherwise the situation appears to be average or below average for stage at treatment and hence in all likelihood for survival.

The most obvious area for improvement is in the earlier diagnosis of bowel cancer. We have begun a detailed analysis of 1969 Iowa bowel cancer data along the lines of the breast cancer and cervical cancers described in earlier reports. It is already clear that early (curable) bowel cancer either is asymptomatic or produces only vague, common symptoms. Unless some method of screening, such as a test for blood in the stool, can be implemented successfully, the outlook for improving the stage of treated bowel cancer is not bright.

TABLE I
STAGING OF INVASIVE CANCERS
IOWA 1973-1974

Site	Cases	Of Staged Cases		
		% Staged	% Localized	% Localized ERG (1)
Colon and rectum	3,109	87	32	44
Breast	2,749	95	57	46
Lung	2,444	74	16	19
Prostate	1,698	84	68	63
Bladder	979	95	87	82
Endometrium	780	92	85	81
Pancreas	636	79	13	16
Stomach	519	79	13	18
Ovary	495	94	29	24
Cervix	439	86	64	45
Kidney	415	88	45	45
Melanoma	277	93	77	74
Oral mucosa	235	86	48	35
Larynx	230	89	70	58

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The authors are associated with the Iowa Cancer Epidemiology Research Center and the Iowa State Cancer Registry. This study is supported by contract #N01 CP 43200.

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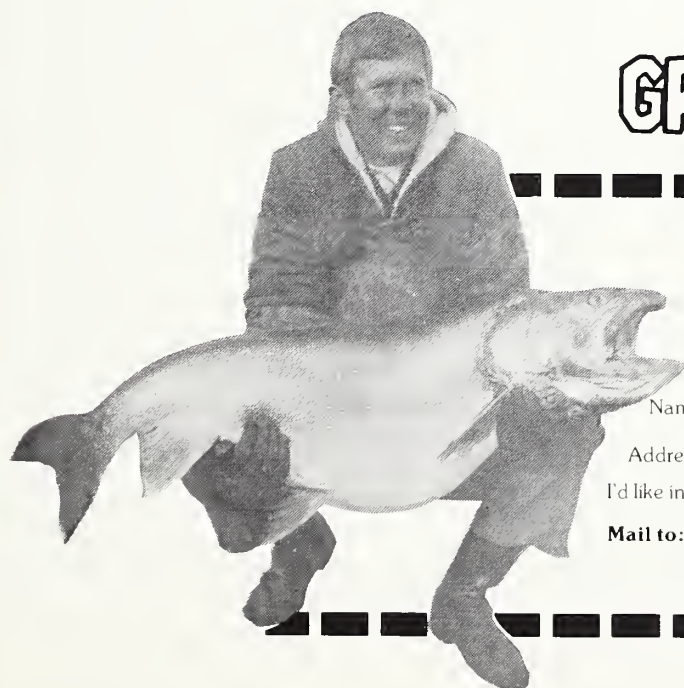
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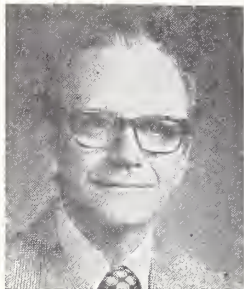
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Editorials

M. E. ALBERTS, M.D., Scientific Editor

CONTINUING MEDICAL EDUCATION

A new enterprise of great proportion has entered our professional life.

Continuing medical education has become official reality, whereas in the past our regular reading of journals and books and our attendance at medical meetings was an individual self-improvement proposition. Now, several states require CME for re-licensure; other states are studying the idea. The AMA operates a Physician Recognition Program for CME. The IMS supports legislation requiring *all* professional and occupational licensees to participate in continuing education as a condition of re-licensure. No recommendation, as yet, has been made on a CME requirement for IMS membership. The provisions of CME, as well as peer review, are rapidly becoming an integral part of our profession, ultimately for the benefit of the patient as well as the physician.

It has become obvious that CME has become big business. Medical colleges, societies, large and small medical centers, and pharmaceutical firms have entered the market, either for a price or as a service. There are, however, increasing numbers of opportunists in the market. There are medical publications which present self-assessment quizzes for which an answer-sheet may be sent to a medical college or a computer data firm. There is a fee of several dollars to correct the exam and certify the results.

Each day our mail contains invitations or announcements of 1, 2, 3 or 4 days of educational experience at some exotic (or not so exotic) place. Some of these programs are very good; others are vague in their recital of content or purpose. Some are underwritten by sponsors from

the drug industry; others by medical colleges. Some are relatively inexpensive, while others are unreasonably costly. Some provide enjoyable outlets for the off-hours, others not; some more vacation than education.

I have no quarrel either with CME or with the reasonable cost of the experience, or with reasonable opportunity for tax-deductions. Yet, there must be some control as well as rational programming of the educational pursuits. At present, through its Physician Recognition Award program, the AMA has several CME categories. The foremost category involves AMA-approved sponsors, while other categories include non-approved sponsors, medical teaching, writing, self-education, as well as involvement in peer review activities. Such categorization is necessary, but sometimes we see obvious irrationality in whether approved sponsors are so much more valuable to the education than non-approved sponsors. All of us have attended local medical seminars or presentations which were far more valuable than others sponsored by a learned center or society. Some of the "big" meetings amount to discussions of interest only to the academic professional; the practicing physician can only rationalize these meaningless discussions by concluding that "at least it's tax deductible." I recall a recent symposium to be centered on new advances in the therapy of pulmonary problems of infants. But, the first paper presented at some length data on the atmosphere of Mars or some such other nebulous place. Some physicians learn more from their individual efforts, such as listening to taped lectures, reading journals and books, and person-to-person discussions with other physicians.

I realize it would be difficult to document the number of hours of self-assessment and self-education. Yet, what of controls over attendance at

(Please turn to page 91)

EDITORIALS*(Continued from page 90)*

approved meetings? Is a receipt for the registration fee valid proof of education? Shall all attendees be observed by proctors to be certain they were awake and alert? Some meetings now have provision that an attendance card be validated by a doorman at each session. This is good, but rather childish. Roll-call sheets to be signed are not the answer; too much opportunity for forgery.

CME is here to stay, probably to be mandatory. Let us not abuse the purpose. If all of us, attendees and sponsors, will be honest about the entire program, our profession will be served well, and our patients will be the ultimate beneficiaries of any additional knowledge we acquire. Let not the opportunists sell us inferior merchandise. Let the price be right. Avoid the frills, but still retain some off-hours outlets. Use talent from all areas, appropriate to those expected to attend the meeting. Give the physician something he can and wants to take home. Often simple, yet meaningful "handouts" are valuable—diagrams, brief summary outlines, algorithms, and the like. A theme is important, not a hodgepodge of unrelated subjects. In that way the physician can be selective in his choosing rather than having to select a little meat from a lot of fat he does not desire.

For the most part, the CME programs are quite good. Constant survey is needed; constant constructive criticism is mandatory. Those who fail to provide what we need will fail. We desire meaningful knowledge—not useless frills that masquerade as education merely to fulfill requirements of CME.—M.E.A.

MEDICAL MISCELLANY

MATERNAL & CHILD HEALTH . . . The IMS Maternal and Child Health Committee met February 16 at Society headquarters with representatives of the State Department of Health to review the Iowa measles situation, compulsory immunization legislation, swine flu program, etc.

MEET MEDICAL STUDENTS . . . Current Scanlon Medical Foundation loan recipients met February 23 in Iowa City with the Foundation Board of Directors to visit informally about their study programs.

Navy Medicine. The time is right.

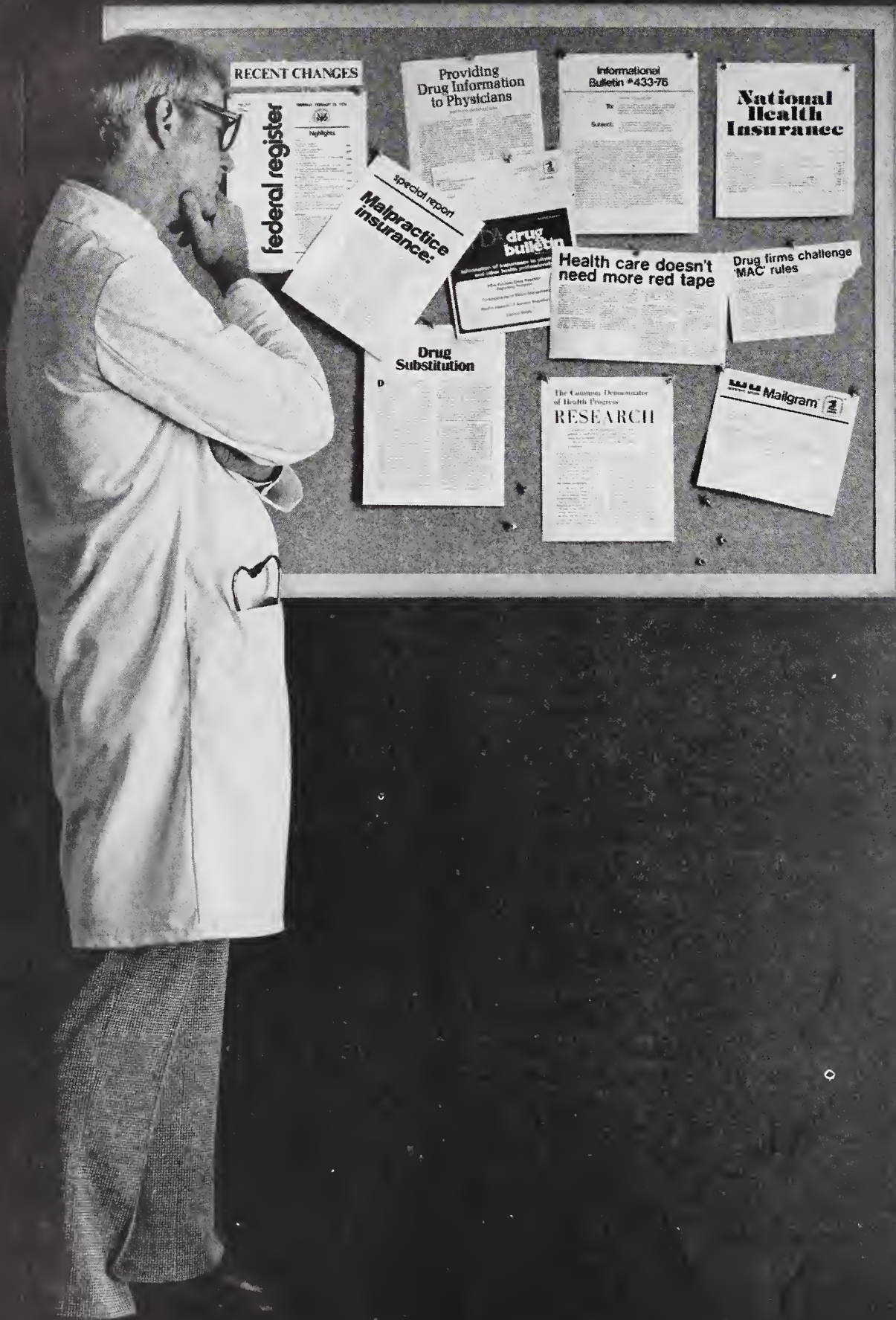
Now's the time to look into Navy Medicine. It was never more attractive than it is today. As a physician in the Navy, you'll practice the finest in patient care and follow-up, in facilities that rank with the top anywhere. With the support of a skilled paramedical and administrative staff. As a General Medical Officer or a Navy Flight Surgeon, or in your own specialty—or in one of ours like aerospace medicine or undersea medicine.

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RECENT CHANGES

federal register

Highlights

Providing Drug Information to Physicians

Partners in distributed care

Informational Bulletin #433-76

For

Subject:

National Health Insurance

special report Malpractice insurance:

drug bulletin

Health care doesn't need more red tape

Drug firms challenge 'MAC' rules

Drug Substitution

The Customary Determinative of Health Progress RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

State Department of Health

SCABIES

Epidemics of scabies usually last 15 years and are followed by a 15-year interval of reduced activity before the next 30-year cycle. The current epidemic began in most parts of the world in 1964 and should abate by 1979. In recent years scabies has been diagnosed nationally on an increasing scale, so Iowa physicians and school officials should be observant for cases and encourage prompt treatment.

Scabies is transmitted by direct contact and is seen most frequently in small children of the same household and as a result of sexual contacts among older persons. Some recent investigations suggest transmission is community based and that schools do not figure prominently in the epidemiology. However, school may be a convenient location for periodic screening of youngsters, particularly during an outbreak.

The diagnosis should be certain before therapy is instituted. Diagnosis preferably should be accomplished by identifying the mite in skin scrapings or at times by cutaneous biopsy. If the mite cannot be detected there should be a review of suggestive features and the more such features, the more positive is the diagnosis.

Prompt treatment is encouraged for all cases. This should include a second application of an insecticide lotion, if this type of product is used. Treatment of all household contacts and sexual contacts outside of the household is recommended. For complete details on this disease and its treatment, refer to Orkin *et al*¹ and the following outline.

INDICATIONS OF INFESTATION

1. Itching, particularly at night. Intensified by

warmth and moisture. (Noticeable itching usually occurs about one month after initial infestation.)

2. Zigzag of sinuous cutaneous lesions 2 to 30 mm (0.1" to 1.2") long with tiny vesicles and papules. (Prime foci of infestations are in thin skinned areas such as breasts, shoulder blades, penis, back of the hands, wrists, between fingers, etc.)

3. Using a hand lens to trace burrows or tunnels to the end, the mite can be located and removed with needle or fine probe. Immersion of the mite into potassium hydroxide or Koenike's fluid and examination under a microscope is confirmatory. Skin scrapings utilizing mineral oil and a scalpel are an alternative method to demonstrate the mite.

4. Chronic condition is indicated by multiple lesions with vesicles, pustules, excoriation and a weeping eczema.

MODES OF TRANSMISSION

1. Almost always, direct personal contact.
2. Less commonly, fomites used by infested persons such as unlaundered bed linens, towels, blankets, clothing.

COMMENT: Scabies tends to be hyperendemic or epidemic in areas of crowded or closely confined living conditions with lowered standards of personal hygiene and sanitation.

TREATMENT

1. Prior to application of any medication, infested persons should thoroughly bathe and soak in a warm water bath for at least 30 minutes. This softens the skin and improves the efficacy of the medication.

2. Apply insecticide lotion to the entire body below the chin. Leave on for the prescribed interval (usually 24 hours).

3. Retreatment is recommended after 7 to 10 days.

1. Orkin, M., Epstein, E. and Maibach, H. I.: Treatment of today's scabies and pediculosis. JAMA 236:1136-1139, 1976.

4. Itching may continue for several days following treatment and does not necessarily indicate continued infestation.

5. Treatment is recommended for all household contacts and sexual contacts outside of the household.

6. Treatment of infants and small children with insecticide lotions should be carefully managed to prevent toxicity. Sulfur ointment (5-10% precipitated sulfur in petrolatum) is an efficient scabicide for infants and small children.

DISINFESTATION

Bed linens, towels, underclothing and other potential sources of infestation or reinfestation should be laundered and dried in a laundry dryer. Wash water and drying cycles should be at the hottest settings allowable for the fabrics. Those items which cannot be laundered should be dry-cleaned.

SCABIES

CAUSE:

Itch Mite (*Sarcoptes scabiei*)

EGG:

1. Where laid: In cutaneous burrows or tunnels
2. Size: 0.15 x 0.1 mm (0.0006" x 0.0004")
3. Incubation period: 3 to 5 days

LARVA:

1. Appearance: Six-legged or hexapod form
2. Duration: 2 to 3 days
3. Where found:
 - (a) Usually in hair follicles, or

- (b) In lateral tunnels, or
- (c) In molting packets under epidermal layers

NYMPH:

1. Appearance: Eight-legged form
2. Duration*:
 - Protonymph (First Stage Nymph)—4 to 6 days
 - Deutonymph (Second Stage Nymph, Immature Female) 4 to 6 days
3. Where Found:
 - (a) In hair follicles, or
 - (b) Moving freely over the skin

ADULT:

1. Appearance:
 - a. Size:
 - (1) Females: 0.33-0.45 mm (0.013"-0.018") x 0.25-0.35 mm (0.0099"-0.0139")
 - (2) Males: 0.2-0.24 mm (0.0079"-0.0095") x 0.15-0.2 mm (0.0059"-0.0086")
 - b. Eight legged
2. Life Expectancy:
 - a. Male: Until copulation
 - b. Female: About one month
 - c. Off the host: 3-4 days
3. Where found: Cutaneous tunnels or burrows
4. Egg production:
 - a. Up to 50 eggs produced during lifetime of gravid female
 - b. Eggs are laid in cutaneous burrows as the female tunnels ahead

General Comments on Biology:

1. Prior to copulation, female will make temporary tunnel. After copulation, gravid female will tunnel up to as much as 30 mm laying eggs as she proceeds up the tunnel.
2. Gravid female may lay as many as 50 eggs during adult life.

* Consensus among some authors is that males are developed directly from the protonymph and the deutonymph is the immature female form.

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Each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); and 25 mg phenobarbital in the immediate release layer.

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

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Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

T-GP-74-B/W

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TEDRAL® Elixir

CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral SA: each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

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Full information is available on request.

Morbidity Report for January, 1977

Disease	Jan. 1977	1977 to Date	1976 to Date	Most January Cases Reported From These Counties
Adenovirus infection	1	1	1	Polk
Amebiasis	2	2	1	Boone
Chickenpox	1329	1329	1834	Linn, Pottawattamie, Scott
Conjunctivitis	253	253	110	Black Hawk, Sioux, Story
Erythema infectiosum	3	3	16	Cedar, Scott
Gastrointestinal viral inf.	3155	3155	3904	Lee, Linn, Story
Giardiasis	4	4	5	Boone, Des Moines, Johnson
Hepatitis A (infectious)	10	10	8	Pottawattamie
B (serum)	6	6	9	Black Hawk, Pottawattamie
Unspecified	5	5	3	Polk
Impetigo	85	85	116	Johnson, Linn
Infectious mononucleosis	87	87	124	Johnson, Linn, Scott
Influenza-like illness	3243	3243	4728	Linn, Madison, Polk
Meningitis, type unspecified	1	1	—	Black Hawk
Mumps	276	276	189	Black Hawk, Fremont, Scott
Pediculosis	17	17	54	Scattered
Pinworms	9	9	6	Polk
Pneumonia	116	116	79	Lee, Scott
Rabies in animals	12	12	6	Howard, Jasper, Woodbury
Rheumatic fever	3	3	2	Black Hawk, Lee, Pottawattamie
Ringworm Body	37	37	43	Benton, Black Hawk, Madison
Scalp	2	2	5	Benton, Woodbury
Rubella (German measles)	37	37	4	Black Hawk, Jasper, Polk
Rubeola (measles)	539	539	13	Dickinson, Webster, Wright
Scabies	134	134	92	Black Hawk, Boone, Palo Alto
Streptococcal infections	1501	1501	1825	Jackson, Johnson, Polk
Tuberculosis, total ill	10	10	8	Scattered
Tuberculosis, bact. positive	9	9	4	Scattered
Venereal diseases: Gonorrhea	504	504	126	Polk, Scott
Syphilis	30	30	35	Black Hawk, Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
Cytomegalovirus infection 1, Herpes simplex 8

TODAY'S CHALLENGE: MAINTAINING PATIENT ACCEPTANCE

IS THERE a "crisis" in the delivery of American medical care?

Some critics say there is. But patients tend to express satisfaction with the medical care they receive. At least the public opinion polls suggest they do.

In various studies conducted in the 1970's, none sponsored by the medical profession, a majority of persons said they are satisfied with their medical care, they can find a doctor when they need one, that costs aren't too burdensome, and that in general the American way of medical care—delivered principally by the private physician in his office or to his patients in the hospital—works well. Here are excerpted findings from several studies:

- A survey of Chicago-area residents by the Continental Illinois Bank found 90% of households with at least one employed person had medical insurance. Respondents indicated overall satisfaction with the extent of employer coverages. Six of 10 said their medical insurance, disability insurance and pension benefits were adequate.

- Roper Reports found that nearly 9 in every 10 (86%) have a family doctor they can call upon. Better than 8 in 10 told Roper interviewers they are "very satisfied" or "fairly well satisfied" with both the quality and availability of their medical care. Although a majority believe costs are too high, 8 in 10 are "very satisfied" or "well satisfied" with the provisions they have for meeting their medical expenses. About 9 in 10 say they have some kind of health insurance.

- A Louis Harris study done for Congress in 1973 on our most serious national problems ranked inflation first, health care delivery 15th out of 16.

- About 7 Americans in every 10 say they are "very satisfied" with their personal state of health, according to the University of Michigan Institute for Social Research.

- The U. S. Office of Consumer Affairs' tabulation of consumer complaints ranked medically-related complaints lowest on a list of 20 categories, accounting for 1% of all complaints. Automobile and home repairs headed the list.

- The Harris Poll respondents ranked medicine's leadership the highest among 16 different professions and institutions. About 7 in 10 say that leaders in medicine "really know what the people want," while only 2 in 10 believe medical leadership is out of touch.

- Chilton Research Services found doctors at the head of the list of occupations according to trustworthiness. On a scale of 1 to 10, Chilton's respondents gave doctors a score of 8.2.

These findings are basically heartening. But they should not engender complacency. Many complicated factors are present in today's medical care picture which deserve and demand attention. Mounting costs head the list. The cost spiral is attributable to various phenomena: increased clinical competence and technology aimed at extending life; the growth of health insurance and its incentives to better care and more comprehensive coverage; the surge in professional liability premiums; greater longevity with increased incidence of chronic illness; steady inflation; the added expenses prompted by federal involvement in care; etc.

Out of this has come a 25-year (1950-1975) jump in percentage of gross national product spent for health care from 4.6% to 8.3%. This kind of increase is not all that alarming when you recognize that health and well being is the commodity in question. What is needed in the future is conscientious attention first to quality and second to economics—by committed, conscientious and capable providers of health care. So, as the preceding excerpts suggest, citizens (patients) will accept and have confidence in the care they receive—and benefit from it.

IN THE PUBLIC INTEREST

When Big Ben looks "a little off"...

Antivert[®]/25 (meclizine HCl) 25 mg. Tablets for vertigo*

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.

■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

***INDICATIONS.** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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About IOWA Physicians

New officers for Mercy Hospital medical staff in Cedar Rapids are—**Dr. Joseph Galles**, president; **Dr. Dale Roberson**, vice president and president-elect; **Dr. Thomas McIntosh**, secretary-treasurer. Elected departmental chairmen are—**Dr. John Parks**, anesthesia; **Dr. G. L. Schmit**, emergency room; **Dr. Gary Hayes**, general practice; **Dr. James Hood**, internal medicine; **Dr. Gerald Shirk**, obstetrics and gynecology; **Dr. Gene Meger**, ophthalmology; **Dr. James Turner**, orthopedics; **Dr. Dennis Charipar**, pathology; **Dr. Walter Block**, pediatrics; **Dr. John Lohnes**, radiology; and **Dr. William Audch**, surgery.

Dr. Anthony C. Catipay, Council Bluffs, attended a three-day course in advanced coloscopy and laser beam usage at Boston University Medical Center. . . . **Dr. Louis George**, Remsen, has been named chief of Floyd Valley Hospital medical staff; **Dr. Glenn Van Roekel**, LeMars, vice president; and **Dr. Daryl E. Doorenbos**, LeMars, secretary. . . . **Dr. Joseph Wojcik** will join the Ackley Medical Center in July. Dr. Wojcik is completing his third year of a family practice residency at Broadlawns Hospital in Des Moines. He received his M.D. degree at U. of I. College of Medicine. . . . **Dr. Donald Reyerson**, Webster City, was guest speaker at a recent meeting of the Eighth District Nurses of Iowa. Dr. Reyerson's topic "A Better Approach to Newborn Care." . . . **Dr. Herbert W. Rathe**, Waverly, was recently presented the Waverly Chamber of Commerce 1976 Outstanding Citizen Award. Dr. Rathe, a Waverly physician since 1926, is co-founder of the Rohlf Memorial Clinic. . . . **Dr. Adrian J. Wolbring**, Mason City, was named a Fellow of the American Academy of Orthopaedic Surgeons at the group's recent annual meeting in Las Vegas, Nevada. . . . **Dr. Wendell Downing** was recently installed as president of the Polk County Medical

Society; **Dr. Donald Sweem** was chosen president-elect; **Dr. Leo Plummer**, secretary-treasurer; **Dr. Lester Beachy**, trustee; and **Dr. Douglas Dorner**, councilor. All are Des Moines physicians.

Dr. L. C. O'Toole, retired LeMars physician, recently presented his medical library to the family practice residency program in Sioux City. Dr. O'Toole's collection dates back to 1929 and includes material on obstetrics, gynecology and internal medicine. . . . New officers of Montgomery County Medical Society are **Dr. Jack Fickel**, president; **Dr. E. M. Sorensen**, vice president; **Dr. Francis Pisney**, secretary-treasurer; **Dr. Glenn Skallerup**, delegate and **Dr. Rodmond Smith**, alternate delegate. All are Red Oak physicians. . . . **Dr. J. B. Baker**, Greenfield, was re-elected chief of staff at Adair County Memorial Hospital; **Dr. N. L. Krueger**, Casey, vice chief of staff; and **Dr. Pat Frankl**, D.O., Greenfield, secretary-treasurer. . . . **Dr. Marvin Jungling** has joined **Drs. M. Christine Webster** and **James L. Skarda** in the practice of urology in Iowa City. . . . **Dr. Franco L. Chua**, Marshalltown, was guest speaker at recent annual meeting of the Marshalltown Area Community Hospital Auxiliary. . . . **Dr. M. C. Jones**, Boone, has been named to the board of directors of the Citizens National Bank in Boone. . . . **Dr. F. M. Ashler**, Hamburg, has been appointed to three-year term on the Commission on Health Care Services of the American Academy of Family Physicians. Dr. Ashler is the immediate past president of the Iowa Academy of Family Physicians.

Dr. E. J. DeLashmutt, Fort Madison, has been named to the board of directors of the Lee County Savings Bank in Fort Madison. . . . **Dr. Robert E. Rakel**, professor and head of the Department of Family Practice at U. of I. College of Medicine, has been elected vice-president of the American

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Insurance Program
Is Important!**

Board of Family Practice. . . **Dr. John E. Tyrrell**, Manchester, was recently named vice chairman of Iowa Statewide Health Coordinating Council.

DEATHS

Dr. Harry D. Harper, 76, longtime Fort Madison physician, died January 1 at University Hospitals in Iowa City. Dr. Harper attended Howard University Medical School in Washington, D. C., and received the M.D. degree at U. of I. College of Medicine. He interned at Freedman Hospital in Washington, D. C. In 1976, Dr. Harper received the Howard University Medical Alumni Award for his service to the medical profession. He was a former chairman of the Iowa Civil Rights Commission and a longtime president of the Fort Madison Branch of the National Association for the Advancement of Colored People; he was an honorary life member of the NAACP. Dr. Harper was a past vice-president of Fort Madison Chamber of Commerce; charter member of Kiwanis Club; former chief of staff at Sacred Heart Hospital and life member of Iowa Medical Society and Lee County Medical Society.

Dr. L. H. Prewitt, 78, died January 16 at Otumwa Hospital. Dr. Prewitt received the M.D. degree at U. of I. College of Medicine; interned at Denver General Hospital in Denver, Colorado; and took graduate training at New York Eye and Ear Hospital and the Eye Institute in New York. He was a member of American College of Allergists, a lecturer and instructor for many years with the Hansel Foundation and the Academy of Ophthalmology and Otolaryngology; past president of Wapello County Medical Society and vice president of American Society of Ophthalmologic and Otolaryngologic Allergy.

Dr. William G. Bessmer, 83, retired Davenport physician, died January 14 in Sun City, Arizona. Dr. Bessmer received the M.D. degree at U. of I. College of Medicine. He had practiced in Davenport for 50 years, retiring in 1965. He was a former chief of staff at Mercy Hospital in Davenport; past president of Rock Island Surgeons Association; fellow in the American College of Surgeons and International College of Surgeons; and life member of Scott County Medical Society and Iowa Medical Society.

Medical Assistants



by BETTY EHLERT, CMA-A

APRIL STATE CONVENTION

The 1977 convention of the American Association of Medical Assistants (Iowa Society) will be April 15-17 at the Sheraton Motor Inn in Mason City. Theme of the convention is "Light Your Way With Learning." See program below.

FRIDAY, APRIL 15

- 4:00- 8:00 P.M. Registration
- 5:30- 7:30 P.M. Executive Council Meeting
- 8:00 P.M. LIGHT THE FLAME Party—Mason City Chapter
- Campaign parties

SATURDAY, APRIL 16

- 7:00-12:00 Noon Registration
- 7:00- 8:30 A.M. Continental Breakfast
- 8:30-10:00 A.M. House of Delegates
- 10:15-10:45 A.M. General Assembly
- Invocation and Flag Ceremony
- Welcome: Arlys Wirtjes, President, Mason City Chapter AAMA; Robert Powell, M.D., President, Cerro Gordo Co. Medical Society; Ken Kew, Mayor, Mason City; Chamber of Commerce representative
- President's Message: Leanna Rist, President, AAMA, Iowa Society, Inc.
- 11:00-11:30 A.M. "2-What's New in Ophthalmology?"
- John B. Dixon, M.D., Mason City, Iowa
- 11:30-12:00 Noon "New Advances in X-ray Therapy"
- B. J. Broghammer, M.D., Mason City, Iowa

EXHIBIT AREA OPEN

- 12:30- 1:15 P.M. Luncheon-Style Show, Roberts Clothes of Charm
- 1:30- 1:45 P.M. Theme speaker
- Mrs. C. O. Adams, President, Iowa Medical Society Women's Auxiliary
- 2:00- 3:00 P.M. "Patient Health and Education"
- Richard Caplan, M.D., Iowa City
- 3:15- 3:45 P.M. Orientation of State Officers

EXHIBIT AREA OPEN

- 6:00- 7:00 P.M. Social Hour
- 7:15 P.M. Banquet
- Master of Ceremonies: E. D. Kennedy, M.D., Mason City
- Installation of Officers
- Jeanne Green, CMA-A, President-Elect, AAMA
- Entertainment: Women's Chorus—River City Arrangement

SUNDAY, APRIL 17

- 7:30- 9:00 A.M. Continental Breakfast
- 8:00- 9:00 A.M. Post-convention Board Meeting
- 9:00-10:00 A.M. "Korean Medicine and Music"
- Dr. and Mrs. Adrian Wolbrink, Mason City
- 10:15-11:00 A.M. "Office Neurology"
- Robert Dinapoli, M.D., Mayo Clinic, Rochester, Minn.
- 11:00-11:45 A.M. "Bio-Feedback Demonstration"
- Technician, Mental Health Center, Mason City
- 11:45-Noon Concluding Remarks: AAMA representative
- Noon Luncheon

Registration:	Non-Members	\$30 (Meals and educational sessions)
	Members	\$25 (Meals and educational sessions)
	Educ. Session	\$7 (Students \$3.50)

NAME	EMPLOYER
ADDRESS	ADDRESS
MEMBER	GUEST
STUDENT	DELEGATE
ALTERNATE	

Return registration to: Mrs. Phyllis Kavars, Registration Chairman, c/o Independent Medical-Surgical Group, 121 3rd N.W., Mason City, Iowa 50401

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WANTED—BUSINESS MANAGER, STUDENT HEALTH SERVICE—Responsible for business activities and personnel functions. Requires minimum education of Bachelor degree. Reasonable (2-3 years) experience in a directly related capacity. Submit resume and names and addresses of three individuals who may be contacted for recommendation to: Dr. Geraldine M. Montag, 202 Marston Hall, Iowa State University, Ames, Iowa 50011. Application deadline March 15, 1977. AN EQUAL OPPORTUNITY AFFIRMATIVE ACTION EMPLOYER.

WANTED—EMERGENCY PHYSICIAN, KEOKUK, IOWA—Starting April, 1977. Percentage Fee for service with guaranteed minimum \$50,000 per year for two days work per week. Address your inquiry to No. 1524, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265 or call direct 415/435-0689.

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PSYCHIATRIC RESIDENCY: Vacancies for positions for July 1, 1977 for those who have a regular Iowa license or can obtain one by reciprocity or via the FLEX. Prepare for career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology Affiliation with University of Iowa. The Stipends are: 1st year, \$21,294; 2d Year, \$22,360; 3d Year \$23,478. Intensity and diversity of training program appreciated best by personal visit. T. B. Mannus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call Collect 712/225-2594.

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President's Page



It was Super Bowl Day and, with some friends, I was watching a game which among us fishermen, would hardly be called a tackle-buster. During an especially dull portion, one of the audience turned to me and announced he was considering suing his daughter's doctor for malpractice. I inquired into the circumstances and was told of a wrist fracture that had healed with considerable deformity. The doctor offered little consolation, said it couldn't be helped and that he was not qualified to do the operation that might improve the situation. He made no offer to refer her elsewhere. His reaction was probably a defensive one but came across to the patient and family as arrogance and indifference. This, of course, aroused hostility and resentment and a desire to retaliate by suing.

It is most unlikely that a competent, concerned, straightforward physician will be sued by an informed, confident patient, honestly dealt with. This is excellent malpractice insurance and the premium is free.

James F. Bishop, M.D.

James F. Bishop, M.D., President

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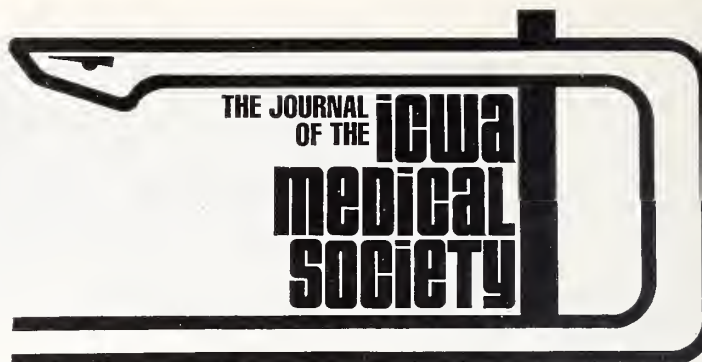
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VOL. 67 No. 4

APRIL 1977

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Postmaster, send form 3579 to the above address.

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IOWA Medical Miscellany

HOUSE OF DELEGATES . . . May 6/7 session of the 1977 IMS House of Delegates is near at hand. 194 Iowa physicians are scheduled to serve as delegates and will represent their county societies in two days of policy making. Preparatory activity has included (1) a March 27 meeting of the IMS Nominating Committee to develop a slate of 1977-

78 candidates, and (2) the distribution of the 1976-77 IMS Delegates' Handbook which includes committee reports and early resolutions. One highlight of the 1977 House sessions will be the May 6 Delegates' dinner at which AMA President Richard Palmer, M.D., will speak and top Society awards will be presented.

IMS/AETNA MAILING . . . The Society's new Liability Insurance Program was highlighted in an early-March mailing to member physicians. The mailing included an informational booklet accompanied by a letter from IMS President J. F. Bishop, M.D., in which he stressed the profession's important and direct involvement. Additional copies of the mailing are available.

LIABILITY BRIEFINGS CONTINUE . . . County society briefings on the IMS/Aetna Liability Insurance Program are scheduled into April. Seven March meetings have occurred with April sessions in Scott County (Davenport—April 5), Cerro Gordo County (Mason City—April 12), and Webster County (Ft. Dodge—April 13). A four-member team (two IMS and two Aetna reps) is presenting information on the new program and responding to inquiries. Interest in the program has been good.

CUSTOMARY UPDATE . . . Iowa Blue Shield undertook its annual updating of customary fee levels in March. This is accomplished through computer analysis of the usual fees of physicians as filed in the preceding year.

WATERLOO APPROVED . . . The Waterloo Family Practice Residency Program became the eighth such approved program in Iowa in February. First residents will enter training July 1.

SCIENCE FAIR . . . The nineteenth annual Hawkeye Science Fair occurred April 1 and 2 in Des Moines. Student exhibitors from throughout the state competed for Fair scholarships and other awards. The IMS and the Scanlon Foundation sponsor the event with Drake University and the DES MOINES REGISTER AND TRIBUNE.

UNIFIED MEMBERSHIP . . . Last year's IMS House of Delegates endorsed the "unified membership" concept and requested by-law language be prepared for consideration in 1977. Under this concept physicians are required to hold society membership at county, state and national levels. The IMS Board of Trustees will recommend the idea be held in abeyance.

HONORED . . . L. H. Jacques, M.D., Iowa City, was honored recently by the Board of Directors of the Scanlon Foundation for his seven years of service as the Foundation's medical student loan officer. A plaque was presented to Dr. Jacques at a dinner with the current student loan recipients in Iowa City.

WORKER'S COMPENSATION . . . County medical societies interested in a program on the medical aspects of the WC program are invited to contact IMS Headquarters. The IMS Committees on Industrial Health and Rehabilitation are working with the State Industrial Commissioner to seek greater physician understanding of this program.



UNIVERSITY ISSUE

Thirty-four years ago this month the JOURNAL of the (then) Iowa State Medical Society identified its April, 1943, issue as a "special 'Iowa City' number," in recognition of the College's "meriting the continued appreciation of all the citizens of the state."

In 1976 I can hardly do better than echo (then) Dean MacEwen's wish, expressed in his editorial introduction, "to express to the members of our State Medical Society the appreciation of the faculty of the College of Medicine for the splendid cooperation we have received in these most trying times."

Wartime help shortages, which delayed accepting and reporting on referral patients, created the "trying times" for Iowa practitioners and their college of which Dean MacEwen spoke in 1943. Other factors—for practitioners, the time-consuming aspects of regulatory requirements, for instance, and the withdrawal of federal support from key programs in medical education—combine to yield the "trying times" of the present for us all.

Whatever the sources of pressure upon us, it is clear that the practicing profession and education will each continue to need the support of the other. We are truly grateful for your help in so many ways, and for this annual opportunity to provide an update on some of the things which we are doing in the College of Medicine, University Hospitals, and throughout the state.—JOHN W. ECKSTEIN, M.D., *Dean, College of Medicine*

Glimpse Into The Future

With the stipulation that their replies would necessarily have to be brief, executive officers of the various departments in The University of Iowa College of Medicine were asked to cite a major problem they would like to see solved in their area of interest in the next decade. Following are their interesting and varied responses to this query.

ANESTHESIOLOGY

JACK MOYERS, M.D.
Professor and Head

Problems in continuing education, basic and clinical research, and malpractice face the specialty of anesthesiology. I have chosen to mention a problem in health care delivery, because I believe it is not only important to anesthesiologists but is of significance to most IMS members.

Anesthesiology shares with other clinical specialties the problem of distributing to patient-consumers what is known and what can be done. The quality of anesthesia care, in its broadest meaning, varies almost unbelievably from hospital to hospital and/or patient to patient. A patient who urgently needs surgery because of intestinal obstruction may be anesthetized by a person with two years of nurse training followed by 18 months of anesthesia training, none of which occurred in an institution otherwise identified with educational programs. A similar patient may be anesthetized by a person with eight years of pre-medical and medical education, followed by a four-year anesthesia training program, all of which took place in a university medical center. Such disparity ought not to exist.

It is improbable we will see the day when every anesthetic is administered by a well-educated physician specialist, an anesthesiologist, any more than we will see all heart disease treated by a cardiologist. It is also true that physician extenders are just as appropriate to anesthesia practice as to other areas of medicine. What is possible, however, is improved education of the non-physician in anesthesia through more effective accreditation of programs and certification of individuals. Moreover, anesthesiologists must greatly increase and strengthen continuing educational opportunities for nurse anesthetists, recovery room nurses, and others who are members of the "anesthesia care team."

At the national level, organized anesthesiologists are assuming a long-overdue leadership role in allied health education. Steps are being taken to establish autonomous accrediting and certifying bodies for nurse anesthetists in an effort to improve the quality of training programs and their graduates. (The Council on Postsecondary Accreditation, COPA, has recently denied recognition to the Council on Accreditation of the American Association of Nurse Anesthetists.) At the state level similar educational efforts are underway. At the time of this writing, a Workshop for Recovery Room Nurses, planned for Ames on April 2, had more than 250 persons pre-registered. This pilot venture will provide important guidelines for future programs.

Identification of anesthesia service needs and improving the quality of anesthesia and related care for all patients are achievable goals that de-

serve and are getting the attention of individual and organized anesthesiologists. The job will not be easy, but it will get done.

ANATOMY

TERENCE H. WILLIAMS, M.D., Ph.D.
Professor and Head

Research advance is an important part of all scientific activity. The roots of anatomical research rest securely in antiquity and to many the word "anatomy" conjurs up images of the dissecting room, the smell of phenol and memories of our first experiences on the way to becoming doctors. Because of these automatic teaching associations (and this Anatomy Department is proud of its reputation as an extremely good teaching organization), many people tend to overlook the equally important role of anatomy in modern research. In the past few years, Nobel prizes have been conferred upon Palade, Claude and DeDuve in recognition of their anatomical discoveries at the cytological level.

Yet today, many anatomy departments are still charged with fulfilling a prodigious teaching mission, serving large laboratory classes for various groups of health professionals. While these duties help to provide our "bread and butter," our need for equal research opportunities (a little "jam," if you like) tends to be somewhat neglected. This need awaits resolution.

Obstacles to achieving this resolution are complex:

1) Overteaching is the reason why some promising young anatomists move to research institutes, leaving the nation short of anatomists. An outstanding graduate may receive 15-20 offers from anatomy departments, but may choose instead to work in a purely research setting. Thus, heavy teaching, coupled with a continuing shortage of good teacher-scientists, represents a major obstacle to research progress.

2) It is recognized that one attracts and keeps good people by paying them competitive salaries. Our graduate student stipends are not competitive; a significant number receive no support, and their teaching duties are relatively

heavy. Whereas steps have been taken in clinical departments to make faculty salaries closer to those in private practice, the same recruiting incentive is not available to attract M.D.s to anatomy.

3) The obsolete view, held by many, that the anatomist has a clearly defined teaching role but has no observable research involvement, is also an impediment. This image cannot fail to deter medical and graduate students who have great talent and research motivation.

In summary, a department's research effort can be measured in terms of the quality and quantity of its available manpower, research funding and productivity.

1) There needs to be recognition of and response to Anatomy's total teaching involvement.

a. An increased number of faculty is absolutely essential for progress; we must work towards more equitable teaching loads for anatomists.

b. Attention needs to be given to every means of increasing teaching efficiency, wherever this can be done without sacrificing quality.

2) There needs to be a conscious effort to recognize and respond actively to Anatomy's research needs.

a. Anatomy's progress would be fostered enormously if faculty and graduate student help could be enlisted in proportion to the size of the teaching mission.

b. Gifted young Ph.D.'s and M.D.'s need to be sought out, recruited and encouraged to seize onto exciting research. This requires competitive stipends, protection from excessive teaching, careful and enthusiastic guidance, and seed money up to the stage at which they may obtain independent research funding.

Even if appropriate measures are taken immediately, overall excellence cannot be expected inside five or 10 years. A great deal has been accomplished in recent years, and it would be important and wise to give recognition and adequate backing to the development of research excellence in Anatomy. This cannot be left to chance.

BIOCHEMISTRY

EDWARD C. HEATH, Ph.D.
Professor and Head

In the past 40 years biochemistry has turned a complete cycle. The earlier, physiological approach to molecular events in the cell gave way to a long period of progress toward a sophisticated understanding of biological activities as they could be studied at the molecular, and even the intramolecular level. Presently, with this wealth of knowledge of structure-function relationships of biomolecules, the field has again directed its

attention to studies on biological processes in cells, tissues, and intact organisms.

Current research in biochemistry is concentrating on the molecular events that regulate the growth, differentiation, and metabolism of cells. In eukaryotic cells, these complex problems may be resolved only when we understand the details of processes involved in communication of biological information across cell membranes—metabolism control, gene transcription, and growth regulation depend upon rapid and highly specific transmission of “biological signals” across membrane organelles of the cell. I anticipate that the next decade shall produce major contributions to a better understanding of this fundamental biological process.

DERMATOLOGY

RICHARD M. CAPLAN, M.D.
Professor and Acting Head

I would like to see the problem of psoriasis solved in the next 10 years. The disease causes a great deal of psychosocial and occupational disability for those who have it (numbering almost 1% of the population). In the past few years much work on epidermal kinetics has been

done that gives me hope that a workable solution might be had within the next 10 years. The biology of epidermal growth and proliferation would appear to be providing useful answers in understanding the disease and bringing it under control. Another avenue of inquiry that might also become fruitful is genetic understanding of the disorder. In addition to providing much additional knowledge about cutaneous biology and disease, an “answer” to the “heartbreak of psoriasis” would then release a lot of resources to attack the many other waiting problems.

MICROBIOLOGY

J. R. PORTER, Ph.D.
Professor and Head

At present we cannot explain why measles-precipitating antibodies appear in the sera of patients with multiple sclerosis. There appear to be several chronic central nervous system diseases of man (kuru) and animals (visna in Islandic sheep and scrapie in sheep in the UK) which are caused by viruses. These apparent viral agents need more attention, because as the life expectancy of man increases chronic central nervous system diseases are likely to become even more important.

No one questions the fact that cytomegalovirus (CMV) is the major cause of such serious birth defects as mental retardation, blindness,

and deafness. Infections with this virus may also constitute a serious problem for immunosuppressed persons, such as recipients of organ transplants and cancer patients. We must learn more about CMV infections, since it is not even clear how the virus is transmitted. There is some indication the virus persists in a latent state, and that it is a reactivated virus that infects the human fetus.

There are many research potentials over the horizon for the serious fungal and protozoan diseases. For example, progress is being made in understanding sleeping sickness, or trypanosomiasis, one of man's oldest and most devastating protozoan diseases. It appears that experimental animals (mice) immunized with BCG (bacillus Calmette-Guerin) are protected against even massive challenge doses of *Babsia* species and *Plasmodium* species. Further research may give

us a better understanding of the mechanism of immunity involved, as well as a practical method of protection against these two important diseases.

Microbiology and immunology have a great opportunity during the next 10 years to help solve a number of problems facing mankind. In bacteriology we know, for example, the simplest form of cell differentiation is spore formation (and germination) in bacteria; if we knew more about the mechanisms involved we might be able to interpret the more complicated cellular differentiation phenomena in high forms of life. There are certain purple pigments in the cell membranes of certain bacteria that are closely related to the visual pigments in the human eye; thus, studies in this area are helping to explain the

extremely important mechanism of vision.

Much of our recent knowledge in genetics and molecular biology has been cradled in microbiology, and this has opened new fields in recombinant DNA and genetic engineering. Additional basic information will be of great value in selecting better strains of organisms for the production of improved bacterial and viral vaccines, for possibly producing substances in the intestine of human beings to correct metabolic defects, for selecting antibiotics for the treatment of diseases, for producing single-cell protein and other substances of nutritional, pharmaceutical, and medical importance.

Microorganisms will need to be used more extensively in improving the environment by recycling wastes and producing energy.

NEUROLOGY

MAURICE W. VAN ALLEN, M.D.
Professor and Head

Multiple sclerosis, of all the major neurological disorders, is most likely to be understood and hence treatable in the next 10 years.

The increased incidence of this disorder in northern climates is important in reference to possible association with childhood infections. A child who does not leave a tropical or subtropical climate until age 15 is less likely to suffer from multiple sclerosis than one who is reared in the North or who moves to northern climates before that age.

The evidence for relationship of multiple

sclerosis to viral infection and aberrant immunological response is increasing and measles remains a contender for a possible role in this disorder.

Currently the only treatment is ACTH or cortico-steroids given during exacerbations. The positive response is statistical but often not impressive individually.

As more is understood about this disease it is easily predictable that a number of sub-types will appear, each requiring different diagnostic criteria and with a few subject to specific management. A high level of laboratory and clinical expertise will then be required to direct proper management for a new spectrum of disease states. Preparation for this likely eventuality should be underway now as research in this disorder is vigorously pursued.

OBSTETRICS and GYNECOLOGY

W. C. KEETTEL, M.D.
Professor and Head

Over 10,000 women die annually from ovarian carcinoma. Unlike cervical carcinoma where there has been a marked decrease in the incidence and mortality, the incidence of ovarian cancer is increasing which perhaps is related to increased longevity. But the most disconcerting

aspect of this disease is that in the last 20 years there has been no improvement in the 25-28 per cent five-year survival rate. The primary reason for this is because early detection is not yet possible, and two thirds of the patients are inoperable when symptoms first develop. Research projects developed to improve early detection include sampling of peritoneal cells via vaginal culdocentesis, vaginal and uterine cytology, ovarian steroid changes and biyearly pelvic examinations. However, none of these have improved the early detection rate.

Preliminary data indicates the presence of tumor specific antigens in epithelial ovarian carcinoma which constitutes 90 per cent of all ovarian malignancies. Although more studies along these lines are needed, it is encouraging to think it may

be possible in the near future to identify specific antigenic markers that could lead to a simple blood test for the early diagnosis of ovarian carcinoma. The prospect for progress is sufficiently good to warrant active research efforts.

OPHTHALMOLOGY

F. C. BLODI, M.D.
Professor and Head

We have two problems in ophthalmology we would like to see solved in the next decade or so.

The first is "senile macular degeneration." It is well known that the macula, that is, the central part of the retina, suffers early and preferentially with senescence and under a variety of pathologic conditions. The area is especially vulnerable to decreased blood flow or impaired oxygen exchange. This part of the retina does not have its own vascular supply, but depends entirely upon diffusion from the choroidal vessels beneath it and from peripheral retinal vessels around it.

Degenerative changes in this area are extremely frequent and occur mainly in the older population. They are a source of great disappointment to the patient and bring some of them nearly to despair. A bilateral lesion will make it impossible for the patient to see clearly, to read or to sew. While the condition does not lead to blindness (because peripheral vision remains untouched) it is nevertheless incapacitating and

may render a patient incapable of performing his or her daily duties.

Actually, I don't think there is a great chance that this problem will be solved within the next 10 years. The main reason is that the basic pathologic changes are concerned with general degenerative changes connected with aging, such as thickening of the Bruch's membrane, arteriosclerosis of the choroidal vessels, etc. A great step forward would be the establishment of an animal model. So far, this has not been possible.

The second great problem in our area is "diabetic retinopathy." With more and more diabetic patients living long enough, nearly all of them will experience damage to the retina. As a matter of fact, this condition is probably the most frequent cause of blindness among adults in this country. So far there is no way we can prevent this complication. We have tried lately to treat it especially with laser or argon light coagulation. This may work in certain rare cases, but in general the prognosis still remains poor and if this condition could be prevented, a great deal of blindness could be avoided.

Work on this condition seems likely to be more successful as we have a number of animal models available. It is quite possible within 10 years the majority of diabetic retinopathies will be prevented.

ORTHOPEDICS

REGINALD R. COOPER, M.D.
Professor and Head

The Orthopedic staff believes the most important problem to be solved within the next 10 years is that of rheumatoid and degenerative joint disease. These disorders affect many parts of the body and cripple millions. In addition to the inestimable pain and suffering they produce, they also account for tremendous economic loss both to individuals and to society in general.

Although it is not likely these problems will be solved totally in the next 10 years, there is reason for optimism that inroads will continue to be made. Hopefully, federal and private support for research into the basic mechanisms will not totally disappear. The marked restriction of federal funds currently is a cause for great concern. There is no doubt that basic research in biochemistry, immunology, genetics, and biomechanics will give the ultimate answers to these afflictions and the support of research in these areas is mandatory. In the interim, we must be content with solutions such as drug therapy, physical measures and surgical procedures such

(Please turn to page 122)



RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

special report
**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

**The Common Denominator
of Health Progress**
RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

as total joint replacement to alleviate some of the most disastrous consequences of these diseases.

There is indeed key research now being done on the biochemistry, ultrastructure, and function of joint cartilage. There is also much investigation into the biomechanical factors which contribute to joint disease. The basic knowledge

gleaned at the intersection of all these disciplines must be enlarged, mainly by further research support. On the other hand, the researchers must heed the admonition to always keep in mind the immediate application of such research to the solution of the patient's problems so maximum well-being can be obtained.

OTOLARYNGOLOGY

BRIAN F. McCABE, M.D.
Professor and Head

Otolaryngology has the same important general problems faced by other medical specialties, including malpractice, escalating insurance fees, and the numerous threats of many kinds of governmental control. One important problem unique to the specialty which is growing in severity and may be amenable to a solution in the next 10 years is sensorineural or nerve deafness.

Significant, handicapping levels of sensorineural deafness are common in the United States and are growing at an alarming rate. This is a product not simply of longevity of Americans but also as a result of trauma, the growing use of ototoxic drugs and noise pollution. Since there is no regeneration of the organ of Corti or pathways medial to it, prevention is at present the only successful method of control. The Occupational Health and Safety Administration has taken a firm lead in this direction and at the present time industry across the nation is frantically setting up hearing conservation programs. It is not enough, however, because by the time these rather primitive screening programs have detected the problem, the hearing loss is so ad-

vanced that it is at handicapping levels already. Slow but steady progression is then the rule even if exposure is eliminated.

As for treatment, we have nothing except a glimmering hope. At a small number of laboratories on the West Coast there is ongoing implantation of electrodes into the organ of Corti for the stimulation of the first order neurons directly, bypassing the organ of Corti. There is an external electronic stimulus. Recently, a number of these patients were tested by an independent team, and it was reported at the last meeting of the American Academy of Ophthalmology and Otolaryngology that these patients did indeed receive significant help from their implanted electrode. The difficulty is that a single electrode will tend to stimulate in a rather restricted area of the cochlea and thus patients have no discrimination ability, not hearing words as such, but hearing cadences, rhythms, clicks and pops, and a good bit of environmental noise. The manufacture and implantation of a multiple array electrode is technically no problem at all, but the design of the "black box is," the box that will encode a vocal stimulus in such a fashion that it can be distributed over the multiple electrode array and then decoded by the brain. A growing effort in otologic research is developing in this direction and hopefully the next decade will see us landing on the otologic Mars.

PEDIATRICS

FRED G. SMITH, JR., M.D.
Professor and Head

Cancer, including leukemia, continues to be the leading cause of death from disease in children in the United States between the ages of 3 and 14 years. It is responsible for almost 12%

of all deaths which occur between the ages of 1 and 14 years.

Considerable progress has been made in the past decade utilizing a variety of new antimetabolite drugs. For example, 10 years ago it was unusual to have a child with leukemia survive longer than 1½ to 2 years and presently survival for 4-5 years is common.

The major obstacles at the present time revolve around the lack of our understanding of

the mechanisms causing malignant proliferation of lymphocytes. Recent exciting studies regarding the relationship of viral agents and several types of animal and human leukemia provide

hope for a major breakthrough in the foreseeable future. Also, efforts to develop antimetabolites which more specifically destroy neoplastic cells are continuing.

PHARMACOLOGY

JOHN P. LONG, Ph.D.
Professor and Head

One of the major health problems is hypertension. Approximately 25 million Americans have elevated blood pressure. Areas associated with ineffective therapy of the disease are many. 1) Detection is still the major problem. Ten to 15 million people are unaware of their elevated pressures and the consequences of untreated symptoms. 2) The etiology of the disease is usu-

ally unknown. 3) It is often difficult to get patients to regularly take their drugs. 4) Newer and better drugs and therapy are needed. In spite of these problems I am an optimist. Look at the products of research during the past 20 years. The dramatic improvements in therapy certainly demonstrate that effective treatment is possible and should be encouraged.

Much has been learned about modes and techniques of therapy. With this background of information, science can be expected to yield further expansion of our knowledge. To benefit all people will require a concerted effort by all Americans.

PREVENTIVE MEDICINE AND ENVIRONMENTAL HEALTH

ROBERT WALLACE, M.D.,
Associate Professor
DONALD MORGAN, M.D.,
Assistant Professor

The central challenge to preventive medicine in the decade ahead is an accurate assessment of environmental influences on chronic disease.

There is presently good epidemiologic evidence that "environmental factors"—defined broadly and considered collectively—play a significant role in determining prevalences of chronic diseases, notably obstructive pulmonary disease, cancer, and arteriosclerosis. In a sense, this discovery is heartening, because it signifies some possibility of reducing the toll of these diseases by changing the circumstances of our lives. What we need to know now are the specific factors (diet, habits, air-, water-, food-borne pollutants, etc.) that increase the occurrence rates of these conditions, together with quantitative estimates of their impact. Human exposure to many environmental insults is not easy to limit: alterations in life style, habits, and the cultural qualities of an industrial society sometimes seem

almost as immutable as heredity. If the modern world environment is to be changed in the name of better health, the projected improvement will have to be substantial, and the evidence pointing to a beneficial effect will have to be compelling.

The field of environmental health now has at hand a surfeit of laboratory data suggesting innumerable adverse effects of chemicals and physical agents—both natural and man-made—on biologic systems. Broad uncertainties attend the extrapolation of these experimental findings to human health.

The problem of developing adequate methods for studying the effects of our changing social environment on health is paramount. What are the health effects of varying population density and changes in family structure, child-rearing practices, content of the arts and entertainments, work and recreational activities, and political policy decisions? Equally important is further study of the anatomy and physiology of our health care system. What effect will changes in the control, organization and financing of medical care have on our well-being? The changes are rapid, but the outcomes are unclear.

Little progress is likely to be made in reducing the prevalence of human disease until well designed epidemiologic studies identify the major hazards prevailing in our real-world environment. This is our difficult, but crucial, assignment for the next 10 years.

PSYCHIATRY

GEORGE WINOKUR, M.D.
Professor and Head

The most important problem relates to rigorously diagnosed psychiatric illness. If in the next 10 years we found a specific etiology and pathophysiology for any of these diagnostic entities, the field will have made a great step forward. At this point, we know about the presence of a genetic factor in such illnesses but this concerns a distal etiology. What is necessary is the elucidation of a proximal etiology, i.e., neurochemical, physiological, or psychosocial for any of the illnesses. The illnesses to which I am specifically referring are affective disorder (manic-depressive disease, depressive disease), schizophrenia, alcoholism, anxiety neurosis and antisocial personality. I single out these five illnesses because they are probably the most prevalent of the so-called functional psychiatric diseases. It may not be possible to find a proximal etiology. By using new methodologies, namely systematic examinations of a new sort, rigorous criteria and genetic constellations, it is possible the great advance within the next 10 years will simply be a restructuring of the diagnostic categories with the isolation of specific autonomous illnesses. What I am saying is that right now it is quite possible a number of separate illnesses are subsumed under the same name, e.g. schizophrenia. If we were

able by the use of the new methodologies to separate patients called schizophrenic into a number of more autonomous illnesses, it will be a major advance toward the definition of study groups for further biological and psychosocial studies.

There is another problem area in terms of teaching. At the present time, departments of psychiatry are the resource for humanism in medical schools. This is most unfortunate. Departments of internal medicine, surgery, family practice and other clinical specialties are equally as responsible for the advancement of a humanistic medicine. This responsibility should not fall on psychiatry alone, and I would like to see a change occur in the next decade.

Finally, psychiatrists deal with two things at the present time: (1) the diagnosis and treatment of specifically defined illnesses, e.g., alcoholism, depression, obsessional neurosis, etc., and (2) psychotherapeutic treatment of problems of living, e.g., marriage problems, family problems. This latter group of problems is an area where expertise is shared with other disciplines, such as psychology and social work. I think it is necessary to define the role of psychiatry in the treatment of these problems of living. Psychiatry's nucleus is in the diagnosis and treatment of rigorously defined illnesses. No doubt psychiatrists will continue to do some psychological treatment relevant to problems of living but this will probably become a relatively minor part of the functioning of the medically trained specialist in psychiatry.

RADIOLOGY

ROLF L. SCHAPIRO, M.D.
Professor of Radiology

The most pressing problem confronting radiology is posed by computed axial tomography (C.T.), a process which can produce pictorial images of the body's interior with a clarity previously achieved only at autopsy.

While its diagnostic usefulness is no longer an issue, C.T. has created significant socioeconomic issues for physicians, hospital administrators, local and national health-planning or regulatory agencies, and society itself. These issues converge on the cost of C.T. devices, demanding

answers to such questions as 1) How many C.T. scanners are needed in this country? 2) Where should they be located? 3) How soon should they be installed?, and 4) What impact on the public's access to this diagnostic modality can be attributed to regulations decreed by governmental health-planning agencies?

The price of the C.T. scan unit is determined primarily by its flexibility, and ranges from \$300,000 for a "simple" head scanner to \$600,000 for a whole-body scanner. Annual operating costs have been reported between \$159,000 and \$456,000. In the summer of 1976, approximately 300 C.T. units, primarily head scanners, were functioning in this country at an estimated operational cost of about \$200 million

per year. If each of this country's 1,366 hospitals with more than 300 beds were to have one C.T. scanner, the annual national expenditure for the purchase and operation of these units would approximate \$500 million prorated over five years. This expenditure could soar to \$853 million, if each of the 2,132 hospitals with more than 200 beds were to operate a scanner.

The scanner of The University of Iowa Hospitals and Clinics was originally the only one to serve this state's population of more than 2,800,000. There are now five units operational or nearly operational in Iowa. On the arbitrary assumption that C.T. scanners are destined to find only brain tumors, the National Association of Blue Shield Plans has reportedly estimated a need of one scanner for every 2,700,000 people.

The attempts of health-planning agencies to develop formulas for rational distribution of these expensive medical machines have not yet been successful. Various formulas consider factors such as population, distance to, the incidence of new neoplasms in a given population, numbers of nuclide-brain scans performed as an index of suspected neurologic disease, numbers of other diagnostic procedures per year, etc.

Since C.T. scanning poses relatively little hazard to patients as compared to invasive angiographic procedures, these scanners may be considered uniquely suitable for smaller community hospitals; on the other hand, the incidence of significant disease tends to be greater in major medical centers, and therefore the greatest utility or yield of positive results can be expected in the latter type of institution. Responsible opinion generally agrees that installation of these

scanners in private physicians' offices is undesirable, often is based on self-referral, leads to over-utilization and is inconsistent with conceptualization of these devices as community resources.

At present, regulations by most health-planning agencies apply only to institutions and do not extend to private office practice. Yet governmental restrictions and even the threat of future restrictions have led to two consequences of doubtful desirability: 1) the shortage of C.T. equipment in institutional settings has in some instances prompted sequestration of such units into private offices; and 2) the threat of impending restrictions has contributed significantly to the rapid proliferation of C.T. equipment in hospitals compelled to "get in under the wire." This has created a sudden demand for production, which makes likely the marketing of devices before research and development are completed, with early obsolescence thus guaranteed by market pressures if not by rapid progress in technology.

Physicians must help patients gain reasonable access to needed diagnostic facilities without shirking the responsibility to make certain that expensive diagnostic maneuvers are not undertaken merely because they are available. Those in the radiologic specialty must make certain that charges for these services remain reasonable and consistent with demonstrable costs and the demands on our professional expertise, so that the absurd but nevertheless currently fashionable phraseology of "moneymaking technology" no longer has any place in the literature pertaining to C.T. scanning.

SURGERY

ROBERT J. CORRY, M.D.

Professor of Surgery
Director, Transplantation Service

Although extirpative surgery will remain important, clinical surgery will undoubtedly move more in the direction of supplementing bodily functions by adding rather than removing something. Many mechanical artificial organs are meeting with increasing success, including portable (wearable) dialysis units, artificial limbs,

eyes, and even hearts which have been successfully implanted into cows. Nevertheless, it is obvious that living tissue is the ideal substitute for impaired living tissue, and its transplantation should be viewed as one sector of the moving front of "constructive surgery."

It is firmly established that the most important factor governing the long-term survival of living cells or organs transferred from one individual to another is the degree of immunogenetic disparity between donor and recipient. Transplantation of a kidney from one identical twin to another should result in both individuals living a normal and full life. In contrast, transfer of a kidney from an unrelated donor source has about

a 54% chance of being successful at the end of one year, according to the 13th ACS-NIH Organ Transplant Registry Report. In our institution, this one-year survival of a kidney from a cadaver donor source approaches 70%, from a live-related donor source, 78%. Transplantation of organs other than the kidney—such as heart, liver, and lung—by necessity must result from donation of an unrelated cadaver donor. Therefore, the major goal for the future of “constructive surgery” must be the *planned specific alteration of immune responsiveness of the recipient to foreign tissue*.

At the present time we are somewhere about halfway to a fully satisfactory solution of the problem of rejection; and yet, from all we know at the present time, there are strong reasons for expecting that a completely workable approach to its control can be devised. Some discoveries in the last few years will undoubtedly lead to a better understanding of the mechanisms of the immune response, and aid in our management and prevention of rejection. In our Transplant Program, we have endeavored to select the most closely matched donor, thereby reducing the amount of foreign histocompatibility antigens presented to the recipient. The brilliant work of J. S. Thompson in our institution has shown that haplotype matched donor-recipient combinations enjoy a significantly greater success than non-haplotype matched patients. We have, therefore, genotyped our cadaver donors and have endeavored to select recipients who share the same haplotype.

In collaboration with R. M. Freeman, Director of our Dialysis Unit, we have shown the administration of leukocyte poor blood prior to renal transplantation has been associated with an increase in one-year survival of the transplant by approximately 15%. Although the mechanism of this phenomenon is unknown, it is expected

that the administration of a low dose of white blood cells on the cell surfaces of which reside the foreign histocompatibility protein antigens has led to a phenomenon of “immunological enhancement.” In essence, this is a paradoxical phenomenon in which a noncytotoxic antibody is produced by prior administration of antigen which blocks or impairs sensitization of the recipient who is presented with the foreign antigenic specificities of the transplanted organ.

Furthermore, the fact that about half of all transplants survive for several years with current immunosuppression regimens shows that a satisfactory immunological relationship can be anticipated in practice much more often than the extreme polymorphism of histocompatibility systems would suggest. In our laboratory, S. E. Kelley and I have shown that hearts transplanted by primary vascular union from one strain of mice to another with a weak immunogenetic disparity between donor and host go through a rejection episode from which they completely recover. Following recovery from rejection, these mice are tolerant to donor strain skin transplants. This paradoxical phenomenon is akin to the administration of multiple blood transfusions in which the recipients possibly are desensitized or are rendered less immune to a particular foreign antigen. J. R. Starling of our Surgical Department and I have shown that when rat parathyroid tissue is passed through tissue culture for three weeks and then transplanted to a different strain of rats, its survival is greatly prolonged. This phenomenon suggests that the immunogenicity of donor tissue is decreased by tissue culture.

When these problems are more fully solved, we will see a major sweep of progress in clinical surgery in which whole organs and tissues can be transplanted without fear of rejection or the overwhelming infection that occasionally follows current regimens of treatment of rejection.

CARDIOGRAPHIC DIAGNOSIS

Staff members at the University of Iowa Hospitals and Clinics have developed a new method for diagnosing the severity of aortic regurgitation. This new method avoids surgical procedures and measures severity with a special type of electro-

cardiogram called the “transphoracic impedance cardiogram” or ICG.

The waveform the ICG produces is much more complex than those produced by other types such as the EKG, the phonocardiogram (PCG) and the echo-cardiogram (ECHO). The ICG has been found to have waves sufficiently consistent for diagnosis. Research has produced gratifying findings as to the diagnostic worth of the procedure.



Family Practice Residency Network

AN INTERESTING VARIETY of people and places are involved in the Iowa statewide program for training resident physicians in family practice.

There are the residents themselves—128 this year, with another 29 to be added in July. There are their mentors—the program directors and medical staffs of the 15 hospitals in seven Iowa communities in which the residency program is being carried out. There are nurses, medical and clerical assistants, and office man-



John Kuncaitis, a third-year resident at Broadlawns-Polk County in Des Moines, checks a dubious young patient.

agers who staff the model offices where the residents gain much of their experience in caring for entire families. There are visiting faculty, program and community liaison staff from The University of Iowa College of Medicine.

There are 150 state legislators, a majority of whose votes provide the state dollars needed to supplement community hospital and federal support for the program (this year's split: \$3,468,582 from the community hospitals; \$539,210 from federal grants, and \$815,000 in state appropriations and College of Medicine support funds).

There are the Iowa Medical Society and the Iowa Academy of Family Physicians whose leadership has consistently supported the program through its various

stages of development. And there are the 11 professional and lay members of the Family Practice Education Advisory Board, who guide the program and present its budgetary needs to the legislature.

That the program is working seems clear from these early results:

- 15 of the 24 who graduated from the program last year are practicing in Iowa, 10 of them in towns of 9,000 or fewer population.

- Increasing numbers of physicians—from Iowa and elsewhere—are applying for the residencies.

- Interest shown by medical students in selecting careers in family practice and other primary care specialties is continuing to increase.

- 38 new family physicians will be added to the medical manpower pool this year as a result of the Iowa Family Practice Residency program, and another 42 will be added next year. The number of graduates will increase to 55 or more by 1979.

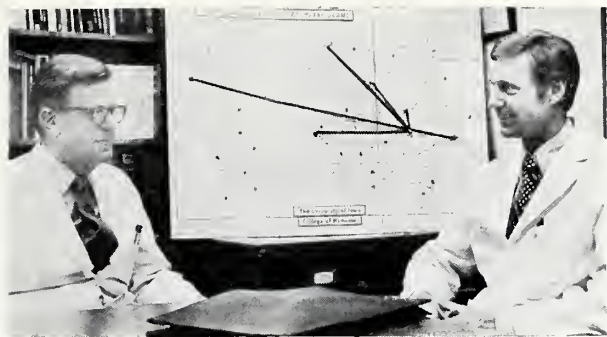
- And even as they train, the 150 residents are adding strength to the manpower pool, easing the burden of their mentors, and helping meet community health needs.

On these pages the JOURNAL presents several of the 128 current residents in the program, along with some of the program staff members and patients who contribute to the educational process.

SUMMARY INFORMATION ON IOWA FAMILY PRACTICE RESIDENCY PROGRAMS

<i>Location</i>	<i>Hospital Sponsors</i>	<i>Program Director</i>	<i>Residents</i>	<i>Initial Year</i>	<i>Satellite Clinics</i>	<i>University Affiliation</i>
Cedar Rapids	Mercy Hospital St. Luke's Hospital	Carl Aschoff, M.D.	23	1971	Mechanicsville	No
Davenport	Mercy Hospital St. Luke's Hospital	Forrest Smith, M.D.	14	1975	DeWitt	Yes
Des Moines	Broadlawns Polk County Hospital	Loran Parker, M.D.	29	1971	—	Yes
Des Moines	Iowa Lutheran Hospital	L. E. Masters, M.D.	20	1974	—	Yes
Iowa City	University Hospitals Mercy Hospital	Robert Rakel, M.D. Rex Coble, M.D.	30	1972	Williamsburg	Yes
Mason City	St. Joseph Mercy Hospital	Richard Munns, M.D.	7	1972	—	Yes
Sioux City	St. Joseph Mercy Hospital St. Luke's Medical Center St. Vincent Hospital	Gerald McGowan, M.D.	5	1976	—	Yes
Waterloo	Allen Memorial Hospital Schoitz Memorial Hospital St. Francis Hospital	C. A. Waterbury, M.D.	0*	1977	—	Yes

* The Waterloo residency will begin training in 1977.



FAMILY PRACTICE NETWORK—

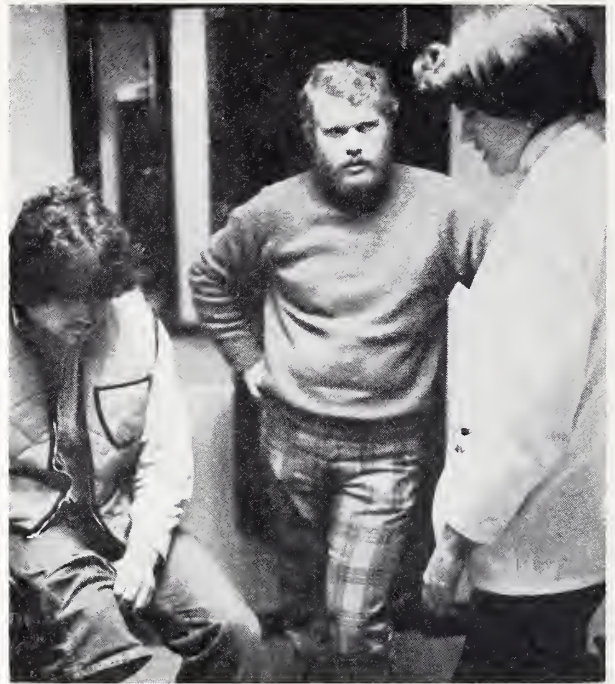
UPPER LEFT—Paul Seebohm, M.D., left, is executive associate dean of the U. of I. College of Medicine and chairman of the Iowa Family Practice Education Advisory Board. He confers with Robert Rakel, M.D., head of the U. of I. Family Practice Department and an advisory board member.

UPPER RIGHT—Roger Tracy, right, is Area Health Education Programs coordinator for the College of Medicine. With him is R. J. Massad, M.D., associate professor of family practice and new coordinator of the Statewide FP Network.

CENTER—Davenport's 4,200 square-foot Family Medical Center is equidistant to Mercy and St. Luke's Hospitals.

LOWER LEFT—Forrest Smith, M.D., Davenport program director, seated at end of table, visits with resident physicians Marvin Ohsann, Lafayette Twyner, Jr., and Kim Brandt; standing center is Administrator D. P. Schmidt.

LOWER RIGHT—The Davenport program includes a satellite office in DeWitt.



FAMILY PRACTICE NETWORK—

UPPER LEFT—This is the satellite office of the U. of I. program located in Williamsburg. The U. of I. Family Practice Center is in Children's Hospital with an FP office on the Oakdale campus.

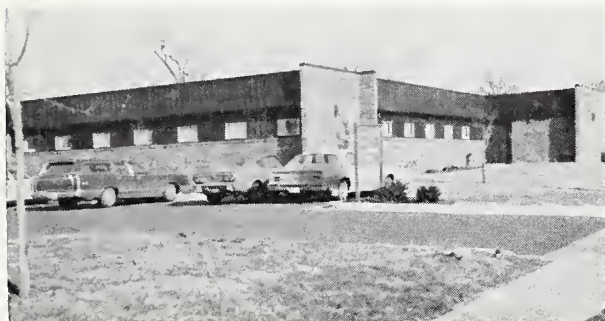
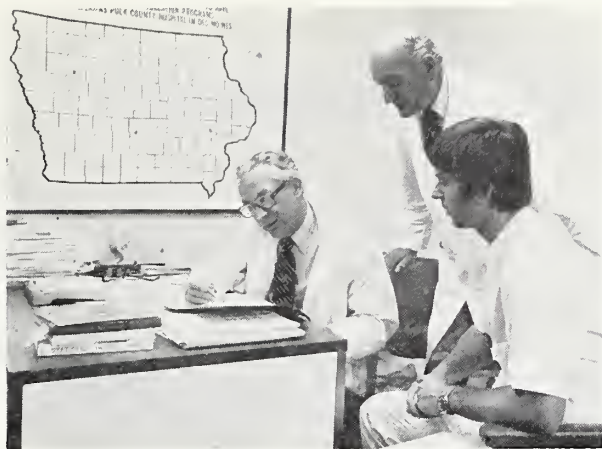
UPPER RIGHT—Jim Wilson, M.D., U. of I. assistant professor of family practice, consults at the Williamsburg office with first-year resident Nancy McElwain.

MIDDLE LEFT—Mason City Program Director Richard Munns, M.D., reviews a patient's record with Alan Wegermann, a resident on rotation from the U. of I.

MIDDLE RIGHT—Waterloo Program Director C. A. Waterbury, M.D., visits site of new Family Practice Center. The Waterloo program is to begin in July.

LOWER LEFT—William Rosenfeld, M.D., Mason City internist, assists in the teaching program.

LOWER RIGHT—The two-story Broadlawns Family Health Center was completed in Des Moines in 1973.



FAMILY PRACTICE NETWORK—

UPPER LEFT—John Hess, M.D., left, associate director, and Loran Parker, M.D., standing, Broadlawns program director, review records with third-year resident James Coddington, M.D.

UPPER RIGHT—Visiting professor at the Broadlawns program is Merlin Strottmann, M.D., U. of I. associate professor internal medicine and orthopedics.

MIDDLE LEFT—The East Des Moines Family Care Center is a teaching facility for the program sponsored by Iowa Lutheran Hospital.

MIDDLE RIGHT—Program Director L. E. Master, M.D., left, confers with third-year resident James W. Rathke, M.D., at Iowa Lutheran.

LOWER LEFT—Sioux City Program Director Gerald McGowan, M.D., left, examines x-rays with first-year residents Dan Rhodes, M.D., and Jim McCabe, M.D.

LOWER RIGHT—The Family Practice Center of the Sioux City program is located in the Sioux City Medical Clinic.

Office of Continuing Medical Education

THE UNIVERSITY OF IOWA College of Medicine operates an Office of Continuing Medical Education which assists groups and individuals throughout Iowa and at The University Health Center itself. This help takes the form of planning, conducting and evaluating continuing medical education offerings.

Fully accredited by the American Medical Association, the U. of I. Office of Continuing Medical Education is qualified to assist in the development of programs that enable participating physicians to acquire Category 1 credit for the AMA's Physician's Recognition Award.

The Office of Continuing Medical Education may be called upon to:

- Assist in planning educational programs, evaluating learner performance and program success.
- Suggest College of Medicine faculty to serve as educators and presentors for community-level programs.
- Provide planning and program coordination between College of Medicine faculty and local sponsors of CME activities.
- Provide information on policies, procedures and criteria for obtaining AMA accreditation of medical education activities.
- Discuss with interested persons new and innovative approaches to continuing medical education.
- Consult with physicians on good quality audio-

visual materials and equipment, patient education and self-instructional packages now coming into use.

The College of Medicine and its Office of Continuing Medical Education will continue to participate in and initiate information exchanges on decisions and legislation which mandate continuing medical education as a condition either of membership in state medical associations and/or re-licensure. The figures below compare the activities of the Office of Continuing Medical Education for the past two years.

	1974-75	1975-76
Number of programs	113	128
Number of registrations	5615	6719
Number of registrants	5035	5080
Number of faculty participations	1229	1396
Number of faculty participants	769	790
Faculty hours (estimate)	5393.0	6106.0
Percent of Iowa doctors enrolled	40	58

The University of Iowa College of Medicine and the Office of Continuing Medical Education seek to respond to the important and life-long educational needs of physicians and allied health personnel. Inquiries regarding services or requests for assistance should be addressed to: *The Office of Continuing Medical Education, University of Iowa College of Medicine, 285 Med Labs, Iowa City, IA 52242 (Phone: 319/353-5763)*

LOCAL LEVEL EDUCATION

The University of Iowa College of Medicine will sponsor six spring meetings to inform community physicians of opportunities open to them in teaching medical students (primarily through the MECO and preceptorship programs).

Program participants will include Kathy Mun-ning and Harold Moessner, M.D., of the U. of I. Department of Family Practice, a medical student, and a local physician. The meetings are intended for physicians, hospital administrators, directors of medical education and directors of nursing education.

The meetings will run from 3:30 p.m. to 8:30 p.m. on the dates and in the places shown below:

- April 19—Mason City Holiday Inn
- April 20—Spirit Lake, Brooks Best Western Lodge
- April 21—Red Oak Holiday Inn
- May 17—Des Moines Holiday Inn (Downtown)
- May 18—Burlington Holiday Inn
- May 19—Dubuque Holiday Inn

Additional information on the meetings may be obtained by contacting the Office of Continuing Medical Education, University of Iowa (319/353-5763).

Largest Ever Graduating Class

GEORGE L. BAKER, M.D., and

JOHANNA JONES

Iowa City

The Class of 1977, with 166 students, is the largest in Iowa history. Forty one percent (68) are remaining in Iowa for training following graduation in May.

IOWA'S GRADUATES are staying in Iowa and going into primary care in increasing numbers. In 1970, eight members of a graduating class of 110 remained in Iowa for their internship year. In 1977 the National Intern and Resident Matching Program (NIRMP) results indicate that 68 of 166 College of Medicine graduates will remain in Iowa for the first postgraduate year of training. This is 41% of the class as compared with 7% of the class of 1970.

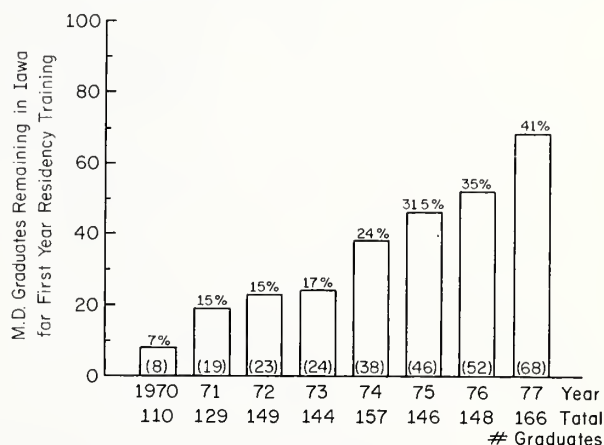
The 1977 class with 166 members is the largest to graduate in the history of the College of Medicine. Since 1970 the number of graduates has increased steadily from 110 to 166. This, coupled with a higher percentage of graduates remaining in the state, will have a favorable impact on the availability of medical care in Iowa.

Forty-eight of the 68 new physicians who are remaining in Iowa will enter training in a primary care discipline: Family Practice, Internal Medicine, or Pediatrics. All together, 120 members of the class of 1977 have elected primary care residency training programs. Since much emphasis in recent years has been on increasing the numbers of primary care physicians and easing the maldistribution of physicians, it is clear that Iowa graduates are responding to the needs of the state.

The curriculum at the College of Medicine has been changing to accommodate these needs. At the end of the first year of medical school, students have an option of participating in a program designed to acquaint them with community medicine. Medical Education-Community Orien-

tation (MECO) places students in community hospitals around the state for 8-10 weeks to observe and assist local physicians. The availability of a variety of preceptorship experiences with Iowa practitioners continues to involve students in primary care during the junior and senior years as part of the full spectrum of medical education.

The recently developed statewide Family Practice Network with seven sites outside of Iowa City, and the new Internal Medicine Program at Iowa Methodist Medical Center in Des Moines are providing much needed opportunities for pri-



mary care training. Thirty of the students remaining in Iowa for primary care training will be in one of these programs.

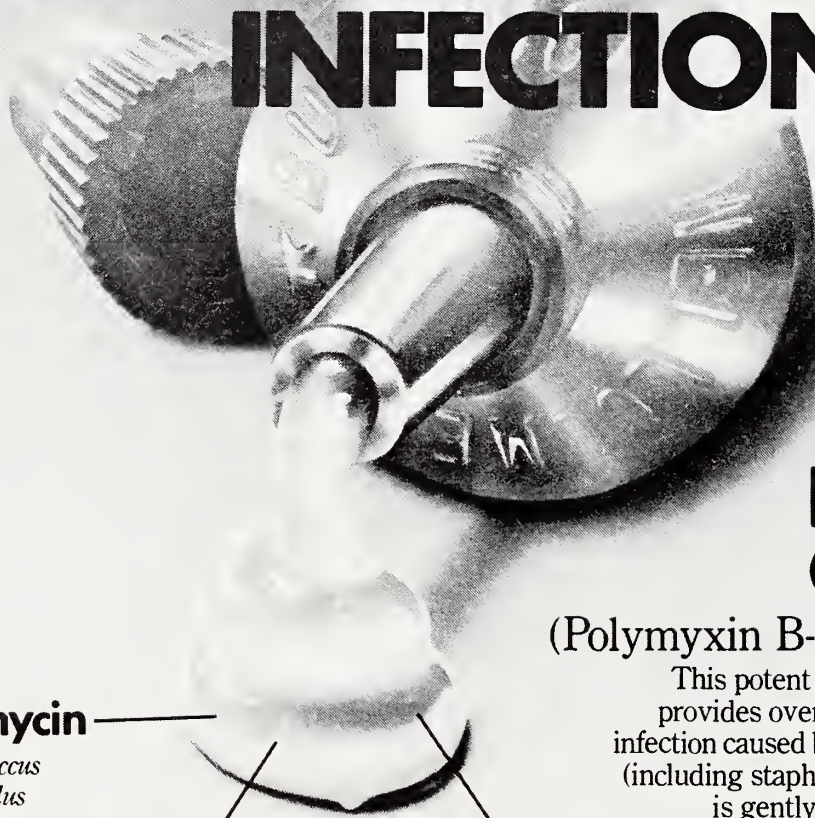
It is likely that many of the 68 graduates who choose Iowa positions for residency training will remain in Iowa to practice medicine. As Paul Seeböhm notes in *The Question Box*, 60% of the physicians who completed Family Practice training programs in 1976 chose to remain in Iowa.

While many of the training programs in Iowa are relatively new, their attractiveness is evidenced by the fact that only one primary care program in the state had unfilled positions following the initial round of matching.

The trend seems clear that the continuum of medical education focus on primary care is responding to the concerns of Iowans that they have access to quality care.

Dr. Baker is Associate Dean for Student Affairs and Curriculum at the University of Iowa College of Medicine. Ms. Jones is Coordinator, Financial Aid.

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(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

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(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin[®] brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is

affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

A Student View of Medical School: 1977

JOE GARRITY

Iowa City

This perceptive view of today's medical student by a U. of I. junior includes mention of the eagerness to get at the important concerns which are beyond the ivory tower.

IF YOU FOLLOW the newspapers to keep track of what has happened in the old ivory towers of medical school since you left, you are probably aware of the "new breed" of student physician—said to be smarter, tougher, more cunning, and more resourceful than students of yesteryear. But as I describe the metamorphosis I see in medical students today, you may conclude today's breed of physician has merely undergone inflation, like everything else, and is still remarkably recognizable.

Ah, the freshpersons. Just count them—175 A-plus students, all from the top of their high school and undergraduate college classes. But within the first month of medical school, you begin to hear them mumbling, "Why do I have to know this?" "There's just too much!"

By the sophomore year, anxiety has ripened. We hear an angry, somewhat paranoid, cynic: "They're doing this just to remind us we don't know it all. This is their last crack at us before we actually begin to practice medicine next year." Two "T's" terrify the sophomore: *Time* (not enough) and *Tests* (too many).

"D's" wham the junior: *Dress, Disease, Death.*

Mr. Garrity is a junior medical student from Davenport. He is the Iowa representative to the Organization of Student Representatives of the American Association of Medical Colleges.

White jackets replace worn flannel shirts, and that symbol of professionalism, the necktie, appears. This is my own junior year, and I confidently report I never have had my system of values so brutally and consistently assaulted. The junior year opens a door on life with all of its highs and lows.

The senior? An individual who senses satisfaction, but also sadness. He sits in solitude, reflecting on the knowledge he has collected and on the awareness that graduation will separate him from a role he's mastered: *the role of student*. Soon he will no longer be that student, but a "professional"—a teacher to his colleagues, his patients, and—if time permits—perhaps to medical students. Isn't this emerging physician reminiscent of someone who roamed the halls when you were in med school?

Today's medical students are also concerned with activities outside the ivory tower. We struggle to remain part of organizations like the AMA and AAMC, to gain representation on all committees (such as the Liaison Committee on Medical Education). We are concerned about charges of "corruption" in medicine and feel we must assume social responsibilities that will enhance the profession.

Attacks on physicians as "Medicaid mill" incompetents who lack social concern have caused the community to devalue the role and status of doctors. Some of us feel a greater transgression, for we see it reflected in the eyes and actions of legislators.

Ever since the passage of Haskell-Klaus (1919), Iowa has recognized its responsibility for high quality care for her indigent ill. With her commitment to them came her commitment to University of Iowa Hospitals and Clinics, the home of those medical students I introduced you to earlier.

STUDENT VIEW OF MEDICAL SCHOOL

(Continued from page 135)

This hospital, which is unlike any other in the state, is a very expensive institution to have around. But it fulfills a very critical and indispensable role in our state health care system because of its activities in medical education, medical research, and in acting as provider of extensive, complex and tertiary patient care.

MEDICAL MISCELLANY

CME ACCREDITATION . . . Iowa health facilities and organizations may still have their continuing medical education programs accredited under the IMS/AMA program. Satisfactory completion of the review process enables the approved institution to grant Category I credit for its CME programs. Further info is available from IMS Headquarters.

BE THE DOCTOR YOU WANT TO BE.

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Of course you know this.

But we students sometimes wonder whether your patients, the public, know it. And we wonder what you are doing to help. We see ourselves actively involved with this unique hospital and with you as you make use of the facility. We look forward to the time when we might work together with you as colleagues concerning these important concerns which reach beyond the ivory tower.

NEEDY PHYSICIANS . . . Society members are reminded of the relief fund for needy physicians operated by the Scanlon Medical Foundation/IMS. This program was created through provisions in the will of Dr. Henry Albert. Requests for assistance under this program should be directed to the Foundation through a county medical society.

POLIO VACCINE . . . New polio vaccine handling requirements imposed on the State Department of Health will impact on Iowa physicians as well. Those physicians who obtain oral polio vaccine supplies from the SDH must complete and return a certification form. The form declares the recipient physician will either (1) make an individual judgment as to the necessity and desirability of the patient receiving the vaccine, or (2) require each patient (parent or guardian) to sign an oral polio vaccine consent form to be retained for three years. This latter provision is required in all public programs. The SDH distributed 21,000 doses of OPV to private physicians in 1976.

MEDICAL ASSISTANTS . . . The 1977 series of Blue Shield workshops for assistants of Iowa physicians began in mid-March and runs into July. Twenty one- or two-day sessions will be held around the state. The sessions provide updated information intended to be useful in handling claims and performing other office functions.

RATES APPROVED . . . State Insurance Commissioner Herb Anderson approved the Aetna liability rate filing March 7. This action was anticipated and completed the formal steps necessary to marketing the coverage.

Appreciation to Physician Preceptors

The University of Iowa College of Medicine extends sincere appreciation to the 206 Iowa physicians who served last year (7/1/75 to 6/30/76) as preceptors for third- and fourth-year medical students and for students in Physician's Assistant Program. These preceptorships are an important

element in the College's outreach effort, they permit students to observe first-hand a medical practice away from the academic setting.

Figure 1 shows the community locations of physicians who served as preceptors for the three groups of students.

1975-76 PRECEPTORS FOR THIRD YEAR REQUIRED PRECEPTORSHIP

SERVED STUDENTS FROM CLASS OF 1977

Ames	Louis Banitt, M.D. Thomas Dry, M.D., Kennedy Fawcett, M.D. (2), James Gohman, M.D. (2), William McCormack, M.D.
Anamosa	Aaron Randolph, M.D. (2)
Atlantic	Roscoe M. Needles, M.D. Milliard T. Peterson, M.D.
Belle Plaine	Clarence Douglas, M.D.
Bettendorf	Rollie Perkins, M.D. (2) Alan Swearingen, M.D. (2)
Bloomfield	Mark Pabst, M.D. (2)
Boone	John Murphy, M.D. (2)
Britt	Norman Thede, M.D.
Burlington	George Gundrum, M.D. Jo Ellen Hoth, M.D.
Carroll	James Jensen, D.O. (2)
Cedar Falls	R. N. Bremner, M.D. (5) John Keiser, M.D. (2), Phillip Rohrbaugh, M.D.
Cedar Rapids	J. L. Banks, M.D. Arthur Barnes, M.D., Thomas Blanchard, M.D., Maurice Estes, M.D., William Robson, M.D. (3), Robert Swaney, M.D. (6), Mark J. Tyler, M.D. (2), John Van Tuyl, M.D., James Ziska, M.D.
Centerville	M. G. Parks, M.D.
Cherokee	Thomas Gary, M.D. Gene Michel, M.D.
Clinton	George York, M.D.
Columbus Jct.	R. Carrell, M.D.
Coralville	Charles Skaugstad, M.D.
Corydon	Keith Garber, M.D.
Council Bluffs	Nosrat A. Massih, M.D.
Creston	Larry Goetz, M.D. (2)
Davenport	Atlee B. Hendricks, M.D. (2) Erling Larson, M.D., Edwin A. Motto, M.D., Forrest Smith, M.D.
Decorah	James Bullard, M.D. T. F. Dynes, M.D.
Des Moines	Robert Anderson, M.D. Dennis Kelly, M.D., Stuart Olson, M.D., Robert C. Smith, M.D., Mark Thoman, M.D.
DeWitt	Wallace Ash, M.D.
Dubuque	John Chapman, M.D. (3)
Durant	J. E. Christiansen, M.D.

Figures in parentheses show number of students if more than one.

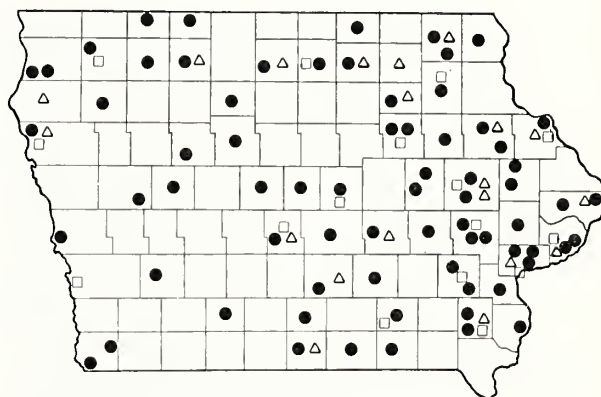


Figure 1. Third year required-preceptorships involved 114 physicians in 71 Iowa communities and served 152 medical students (• indicates locations). The fourth year elective-preceptorship involved 26 physicians in 20 communities and served 28 medical students (Δ identifies community). The Physician's Assistant preceptorship involved 66 physicians in 16 communities (□ identifies community).

Emmetsburg	Carlyle Moore, M.D.
Estherville	D. E. Walters, M.D.
Fort Dodge	Daniel Cole, M.D.
Grinnell	David Ferguson, M.D. Raymond Light, M.D. (2)
Hamburg	Fredric Ashler, M.D.
Hawarden	Edward Eneboe, M.D.
Hopkinton	Herbert Gearhart, M.D.
Humboldt	James Coddington, M.D.
Iowa City	Donald Cassady, M.D. Craig Champion, M.D. (2), Anthony Colby, M.D., Larry Rigler, M.D., Wayne Tegler, M.D.
Kalona	Charles Beckman, M.D.
Knoxville	Earl McKeever, M.D.
Lake City	Paul Ferguson, M.D.
Manchester	Mary Ann Arends, M.D. (2)
Manilla	John Hennessey, M.D.
Marengo	Burns Byram, M.D. (2)
Marion	Paul Orcutt, M.D.
Marshalltown	Charles Bendixen, M.D. E. C. Jacobs, M.D.

Mason City	George West, M.D.	Sheldon	R. E. Griffin, M.D.
Monticello	Paul Jacobson, M.D.	Shenandoah	Kenneth Gee, M.D.
Mount Pleasant	Phillip Couchman, M.D. (2)	Sioux City	A. W. Horsley, M.D.
Warren Scott, M.D.		William Jackson, M.D., George Spellman, M.D., Donald Wag-	
Muscatine	R. W. Asthalter, M.D.	ner, M.D., Martin Zucker, M.D.	
Fred Colby, M.D.		Spirit Lake	Donald Rodawig, M.D.
New London	Harry Readinger, M.D.	Spencer	J. E. Kelly, M.D.
Newton	Marvin Moles, M.D.	Tipton	Robert Kent, M.D.
Oelwein	Harold Hallberg, M.D.	Vinton	Sherman Anthony, M.D.
Orange City	Paul Vander Kooi, M.D. (2)	D. C. Weideman, M.D. (2)	
Oskaloosa	Robert Collison, M.D. (4)	Washington	Gerald Nemmers, M.D.
Sidney A. Smith, M.D.		Waterloo	Hridaya Basu, M.D.
Ossian	Ignatius Green, M.D.	William Drier, M.D., Robert Morrison, M.D.	
Ottumwa	William Maxiner, M.D.	Waukon	Louis B. Bray, M.D. (3)
Oxford	R. J. Hennes, M.D.	Waverly	William Hall, M.D.
Rockford	R. G. Barrett, M.D. (2)	James Rathe, M.D.	
Russell	L. C. Hermann, M.D.	West Liberty	Howard Palmer, M.D.
Saint Ansgar	William Owens, M.D.	Winthrop	A. E. Mayner, M.D.

1975-76 PRECEPTORS FOR FOURTH YEAR ELECTIVE PRECEPTORSHIP

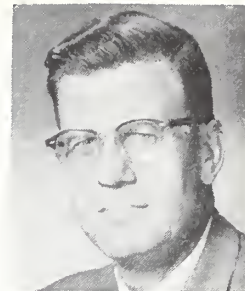
SERVED STUDENTS FROM CLASS OF 1976

Britt	Norman Thede, M.D.	Emmetsburg	James L. Coffey, M.D.
Cedar Rapids	John Bank, M.D.	Carlyle Moore, M.D.	
Arthur Barnes, M.D.		Grinnell	David Ferguson, M.D.
Charles City	Werner P. Pelz, M.D. (2)	H. R. Light, M.D.	
Clinton	Jerald Kreiter, M.D.	LeMars	Donald Faber, M.D.
Gregorio Lauz, M.D.		Manchester	Mary Ann Arends, M.D.
Corydon	Keith Garber, M.D.	Marion	Paul Orcutt, M.D.
Davenport	Erling Larson, M.D.	Mount Pleasant	Phillip Couchman, M.D.
Decorah	James Bullard, M.D.	Muscatine	John Ellis, M.D.
Des Moines	Charles Burr, M.D.	New Hampton	James Young, M.D.
Dubuque	Robert Melgaard, M.D. (4)	Pella	Stewart Kanis, M.D.
		Sioux City	William Horsley, M.D.
		Andrew C. Hyden, M.D., William Jackson, M.D.	
		Waverly	James Rathe, M.D.

1975-76 PHYSICIAN'S ASSISTANT PROGRAM PRECEPTORS

Cedar Rapids	W. Davis, M.D.	Marshalltown	D. Eggers, M.D.
Council Bluffs	G. Klock, M.D.	T. Foley, M.D.; A. Lund, M.D.; R. Mandsager, M.D.; P. McFad-	
Des Moines	M. Hirsch, M.D.	den, M.D.; D. Reading, M.D.	
Veterans Administration Hospital: A. Bekhrad, M.D.; R. Bernardi,		Mason City	M. Alcorn, M.D.
M.D.; P. Black, M.D.; G. Bullock, M.D.; L. Dragstedt, II, M.D.;		B. Dunker, M.D.; L. Fane, M.D.; W. Garrett, M.D.; J. Justin,	
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M.D.; L. Palumbo, M.D.; C. Pun, M.D.; J. Siddiqui, M.D.		Mount Pleasant	Mental Health Institute:
Broadlawn Polk County Hospital: M. Abrams, M.D.; J. Hess,		R. Aldona, M.D.; J. Hanson, M.D.; S. Lee, M.D.	
M.D.; L. Parker, M.D.; S. Sands, M.D.; U. Lee, M.D.		Muscatine	Muscatine Community Health Center:
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ritt, M.D.		Primghar	A. Smith, M.D.
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M.D.; I. Ponseti, M.D.; R. Widmer, M.D.		Waterloo	L. Tan, M.D.
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Besten, M.D.; W. Ferguson, M.D.; J. Starling, M.D.; J. Thomp-			
son, M.D.			

The Question Box



by PAUL M. SEEBOHM, M.D.

MANPOWER SITUATION

Dr. Seebohm is Executive Associate Dean of The University of Iowa College of Medicine. He is responsible for general administration as well as programs in primary care training and physician retention.

Is there really a doctor shortage?

There is no question but that a shortage of physicians existed in the mid-sixties, which—had it not been addressed with an increase in enrollments in medical colleges—would by now have been critical. The doubling of American medical graduates, coupled with the immigration of large numbers of foreign medical graduates, has largely corrected the doctor shortage.

If that is so, why are some Iowa communities still without doctors?

The doctor shortage has always been known to be selective, in that it was the greatest among primary care physicians, i.e., family physicians, general internists and pediatricians—and to a lesser degree among surgical and medical specialists. Since most physicians in small towns were generalists and the physicians in the cities specialists, the shortage was more conspicuous in the rural areas of the state. The real problem, then, has been more than an overall shortage of doctors—rather, there has been a critical loss of one kind of doctor, namely, the general practitioner, and until his numbers have been reinstated there will be some small communities without enough physicians.

What is being done in Iowa to correct the deficit of generalists?

Back in 1969 the College of Medicine initiated a program to develop family practice physicians

in Iowa. A Department of Family Practice was created, and by 1971 undergraduate and residency training programs were in operation. Special legislation in 1973 created the Statewide Family Practice Residency Training Network which is designed to produce over 50 family physicians a year. In addition, a new emphasis on general internal medicine residency training has been developed at University Hospitals and at Methodist and VA Hospitals in Des Moines.

Are the newly trained family physicians staying in the state?

There was 60% retention of the first large (24) graduating class in 1976. Two-thirds of those remaining in Iowa located in towns of 9,000 or less.

If the training of family physicians is going to resolve the physician shortage, why do we need physician's assistants?

Physician's assistants increase the quantity and improve the quality of services rendered by a physician. They relieve the physician of much of the "busy work" of medical practice so he or she has more time to provide the sophisticated services only a physician is trained to perform. Furthermore, after working on site with a physician the P.A. can often be of considerable help to the supervising physician in providing services in nursing homes, satellite offices and emergency rooms.

Will the new family physicians practice alone in small towns?

Not very often. Modern medicine changes so rapidly that physicians in professional isolation soon tend to become out of date, demoralized and fatigued. To keep pace they must have professional associations and some opportunity for relief from duty. Most of those completing FP resi-

QUESTION BOX

(Continued from page 139)

dencies and staying in Iowa have joined or formed group practices. This trend is likely to continue. Consequently, a community will more likely succeed in recruiting if its established physicians are supportive of group practice, and if there is an opportunity for young physicians to join or help establish a medical group.

How will people in towns of 500-2,000 receive care if doctors don't settle in them?

Most towns this size are near communities of 5,000 or more. The larger town can support groups of physicians who can provide care to small satellites in different ways. A physician can visit the satellite with a P.A. who may precede the doctor and/or remain to finish providing care after he leaves. In some situations a transport system is possible to move patients to the larger community.

What has this activity done to retain physicians?

After progressively losing physicians in the '60's

Iowa has now turned the corner. There are over 80 more physicians in Iowa now than in 1970.

How interested are the Iowa medical students in the new primary care programs?

Last year over 75% of the senior students started internships or residencies in primary care specialties. The family practice network alone had 378 applications for 62 first-year positions.

Are we making progress in keeping Iowa graduates in Iowa for residency training?

Yes. Last year 52 (35% of the class) students selected an Iowa internship or residency compared to 8 (7.2% of the class) in 1970.

Where do we go from here?

Concentrate on physician placement. It is now important to see that new physicians locate in viable practice settings in need of physicians. To this end the IMS Placement Service and the Office of Community-Based Programs in the College of Medicine have worked closely with residency program directors in bringing together the new physician seeking a practice location and the community in need of a physician's services.



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Editorials

M. E. ALBERTS, M.D., Scientific Editor

SALUTE THE COLLEGE OF MEDICINE

It's appropriate this issue of the *JOURNAL OF THE IOWA MEDICAL SOCIETY* be dedicated to the University of Iowa College of Medicine. Spring evokes visions of buds and flowers, the renewal of the bounties of the earth, and a reawakening of life. So it is with the education of the physician. The professional school stimulates his mind, fosters his endeavors for knowledge, and lends maturity to the development of the physician. Yet, the task is not complete at the time of graduation. Growth continues, and the College fosters this as well.

The recent annual report from the Department of Continuing Education of the College of Medicine presents facts which are enlightening. In this salute to the College, let me allude to some of these facts, for they clearly demonstrate that the College is for all Iowa physicians. The functions of the College are not limited to Iowa City. There were 128 formally structured continuing medical education programs in 33 Iowa communities this past year. There were 6,719 registrants for these programs, and 790 individuals from the College participated. It is estimated that 58% of Iowa's

medical practitioners participated in these programs along with registrants from many other states and foreign countries.

Further, the faculty involved itself in guest speaker activities, patient services, consultations via telephone, and the development of educational affiliations. In response, practicing physicians were hosts to students undertaking preceptorships and participating in the Medical Education-Community Orientation (MECO) program in community hospitals.

Richard M. Caplan, M.D., associate dean, Continuing Medical Education, emphasized in his report the College is anxious to respond to the educational needs and desires of physicians and allied health personnel. Furthermore, individualized consultation, traineeships and educational programs are available on request. It is obvious the University of Iowa College of Medicine is not a cloister for aging professors bent on making life miserable for the medical student. This is a dynamic community of dedicated educators and clinicians willing and able to serve the entire professional community. To these persons who have a heart and who are interested in the medical care of all the people of Iowa we dedicate this issue of our *JOURNAL*.—M.E.A.

MID-APRIL CONFERENCE

The Spring Conference of the Raymond Blank Memorial Hospital for Children will be April 14 and 15 in Des Moines. Speakers include Benjamin M. Kagan, M.D., professor of pediatrics, University of California at Los Angeles; Saul Krugman, M.D., professor, New York University; Alvan Ja-

cobs, M.D., professor of dermatology and pediatrics, Stanford University Medical Center; W. E. Bell, M.D., professor of pediatrics, University of Iowa, and James E. Rasmussen, M.D., Department of Dermatology, Rochester, N. Y.

Additional information about the conference may be obtained by contacting W. J. McAveney, M.D., acting director, Pediatric Education, Raymond Blank Memorial Hospital for Children, 1200 Pleasant, Des Moines, Iowa 50308.

State Department of Health

RABIES

The latest "Recommendations of the Public Health Service Advisory Committee on Immunization Practices" on rabies are provided.

In addition, a summary of the results of the examinations of animals in the two Iowa laboratories from 1964 through 1976 is included with a map showing the confirmed animal rabies in Iowa for 1976. The Iowa State Department of Health is

continuing to offer consultation to Iowa physicians regarding possible rabies exposure. The number to call from 8 a.m. to 4:30 p.m. is 515/281-5424 or 5643. The number for after hours, weekends or holidays is 515/281-5559. The same numbers can be used to request Hyperab Serum and Duck Embryo Vaccine. The new "Human Diploid Cell Rabies Vaccine" may be licensed within the next several months. When it does become available we will notify Iowa physicians.

INTRODUCTION

Although rabies rarely affects humans in the United States, every year thousands of persons receive rabies prophylaxis. Managing those who have possibly been exposed to rabies infection is of paramount importance. The following is an interpretation of both the risk of infection and the efficacy of treatment. It incorporates many current concepts of the World Health Organization Expert Committee on Rabies.

The problem of how to treat persons bitten, scratched, or otherwise exposed to rabies by animals suspected of being infective is a perplexing one for physicians. All available methods of systemic treatment are complicated by instances of adverse reactions, a few of which have resulted in death or permanent disability. Furthermore, decisions on management must be made immediately, because the longer treatment is postponed, the less likely it is to be effective.

Data on the efficacy of active and passive immunization after rabies exposure have come principally from studies with animals. Because rabies has occasionally developed in humans who had received antirabies postexposure prophylaxis, the efficacy of vaccine has been questioned. Evidence from laboratory and field experience in many areas of the world, however, indicates that post-exposure prophylaxis is usually effective when appropriately used.

Rabies in the United States

Rabies in humans has decreased from an average of 22 cases per year in 1946-1950 to only 1-3 cases per year since 1960. The number of cases of rabies in domestic animals has decreased similarly. In 1946, for example, there were more than 8,000 cases of rabies in dogs, compared with 129 in 1975. Thus, the likelihood of humans being exposed to rabies by domestic animals has decreased greatly, although bites by dogs and cats continue to be the reason for giving the majority of anti-rabies treatments.

The disease in wildlife—especially skunks, foxes, raccoons, and bats—has become increasingly prominent in recent years, accounting for more than 70% of all reported cases of animal rabies every year since 1968. Wild animals constitute the most important source of infection for humans and domestic animals in the United States today. In 1975 only Idaho, Vermont, Hawaii, and the District of Columbia reported no wildlife rabies.

Nerve tissue origin rabies vaccine of the Semple type (NTV)—no longer available in the United States—was used almost exclusively until 1957, when duck embryo origin vaccine (DEV) was licensed. Treatment failure rates for the 2 vaccines were not significantly different, and the lower incidence of central nervous system reactions with DEV made it preferable to NTV.

Effectiveness of Antirabies Treatment in Humans

Comparative effectiveness of treatment can be judged in the United States only by reported failures. During the years 1957-1971, when both vaccines and antirabies serum were available, 6 of the 125,000 NTV-treated persons died of rabies (1/20,800), and 12 of the 310,000 treated with DEV (1/25,800) died. An estimated 105,000 persons were treated with DEV in 1972-1975; only 1 rabies death was reported. Fatalities have been reported in several cases in which the course of treatment was not started immediately or was not completed.

RABIES IMMUNIZING PRODUCTS

Duck Embryo Vaccine (DEV)

DEV is a killed vaccine prepared from embryonated duck eggs infected with a fixed virus and inactivated with beta-propiolactone. It is supplied as 1-ml, single-dose vials of lyophilized vaccine with diluent ampoule.

Rabies Immune Globulin, Human (RIG)

RIG is antirabies gamma globulin concentrated by cold ethanol fractionation from plasma of hyperimmunized human donors. Neutralizing antibody content is standardized to contain 150 International Units (IU) per milliliter. It is supplied in 2-ml (300 IU) and 10-ml (1,500 IU) vials for pediatric or adult use.

Antirabies Serum, Equine (ARS)

Antirabies serum is a refined, concentrated serum obtained from hyperimmunized horses. Neutralizing antibody content is standardized to contain 1,000 IU per vial. Volume is adjusted by manufacturer on the basis of antibody potency in each lot. Currently a 1,000-IU vial contains approximately 5 ml.

Reactions

Local reactions to postexposure treatment with DEV are very common. Most patients experience pain, erythema, and induration at the injection site. Approximately 13% have itching at the site. Systemic symptoms (fever, malaise, myalgia) occur in 33%, usually after 5-8 doses. Anaphylaxis develops in less than 1% of persons receiving DEV and may occur after the first dose, particularly in persons previously sensitized with vaccines containing avian tissue. Neuroparalytic reactions occur rarely with DEV. Between 1958 and 1975, 5 cases of transverse myelitis, 7 cases of cranial or peripheral neuropathy, and 9 cases of encephalopathy (2 fatal) were reported among an estimated 595,000 recipients of DEV. Neuroparalytic reac-

tions were estimated to occur at the rate of 1 case for every 2,000 of the now discontinued NTV.

Local pain and slight febrile response may follow receipt of RIG. Although not reported for RIG, angioneurotic edema, nephrotic syndrome, and anaphylaxis have been reported but rarely after routine injection of immune serum globulin (ISG). These reactions occur so rarely that the causal relationship between ISG and these reactions is not clear.

ARS produces serum sickness in at least 40% of adult recipients; reaction rates for children are lower. Anaphylactic reactions may occur. When ARS is indicated, the patient should be tested for sensitivity to equine serum. (In rare instances the sensitivity test has induced anaphylactic reaction.)

Because adverse reactions are associated more frequently with ARS than with RIG, and ARS might sensitize recipients to equine protein, RIG is the product of choice. ARS should be used only when RIG cannot be obtained within 24 hours.

Because adverse reactions are associated more frequently with ARS than with RIG, and ARS might sensitize recipients to equine protein, RIG is the product of choice. ARS should be used only when RIG cannot be obtained within 24 hours.

RATIONALE OF TREATMENT

Every possible exposure to rabies infection must be individually evaluated.

In the United States the following factors should be considered before specific antirabies treatment is initiated:

Species of Biting Animal

Carnivorous animals (especially skunks, foxes, coyotes, raccoons, dogs, and cats) and bats are more likely than other animals to be infected with rabies. Bites of rabbits, squirrels, hamsters, guinea pigs, gerbils, chipmunks, rats, mice, and other rodents have never resulted in human rabies in the United States and almost never call for antirabies prophylaxis.

Circumstances of Biting Incident

An UNPROVOKED attack is more likely to mean that the animal is rabid. (Bites inflicted on a person attempting to feed or handle an apparently healthy animal should generally be regarded as PROVOKED.)

Type of Exposure

Rabies is commonly transmitted by inoculation with infectious saliva. The likelihood that rabies

(Please turn to page 146)

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Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

SUSTAINED ACTION



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CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

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Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two table-spoonfuls every four hours.

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Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

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Full information is available on request.

Morbidity Report for February, 1977

Disease	Feb. 1977	1977 to Date	1976 to Date	Most February Cases Reported From These Counties
Adenovirus	2	3	2	Linn, Polk
Amebiasis	3	5	12	Boone
Brucellosis	1	1	9	Dubuque
Chickenpox	1697	3026	3259	Clinton, Dubuque, Pottawattamie
Conjunctivitis	267	520	439	Black Hawk, Linn, Story
Erythema infectiosum	18	21	2	Polk, Webster
Gastrointestinal viral inf.	4248	7403	9286	Bremer, Buchanan, Linn, Story
Giardiasis	6	10	9	Boone, Cerro Gordo, Henry
Hepatitis, A (Infectious)	4	14	20	Polk, Pottawattamie
Hepatitis, B (Serum)	4	10	14	Linn, Polk, Pottawattamie
Impetigo	77	166	230	Polk, Warren
Infectious mononucleosis	143	230	263	Johnson, Linn, Scott
Influenza—lab confirmed	15	15	55	Boone, Johnson, Linn
Influenza-like illness	20234	23477	16295	Black Hawk, Linn, Story
Meningitis, bacterial	1	1	1	Black Hawk
Meningococcal, meningitis	1	1	6	Johnson
Mumps	390	666	407	Black Hawk, Harrison, Linn
Pediculosis	38	55	126	Scott, Washington
Pinworms	5	14	7	Black Hawk, Scott
Pneumonia	80	219	278	Dubuque, Lee, Scott
Poliomyelitis	1	1	0	Shelby
Rabies in animals	2	14	9	Hamilton, Mitchell
Rheumatic fever	2	5	9	Decatur, Scott
Ringworm, body	42	80	68	Scattered
Ringworm, scalp	1	3	7	Clarke
Rubella	35	72	5	Jasper, Johnson, Polk
Rubeola	500	1039	16	O'Brien, Polk, Webster
Scabies	119	253	142	Black Hawk, Clayton, Polk
Streptococcal infections	2256	3735	4875	Johnson, Polk
Tuberculosis, total ill	4	14	19	Polk
bacterial post	3	12	16	Polk
Venereal diseases				
Gonorrhea	450	954	1173	Black Hawk, Polk, Scott
Syphilis	30	60	73	Black Hawk, Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
Herpes simplex 4; Herpes zoster 1; Mycoplasma pneumoniae 1

infection will result from exposure to a rabid animal varies with the nature and extent of the exposure. Two categories of exposure should be considered:

Bite: Any penetration of the skin by teeth.

Nonbite: Scratches, abrasions, open wounds, or mucous membranes contaminated with saliva.

Vaccination Status of Biting Animal

A properly immunized animal has only a minimal chance of contracting rabies and transmitting the virus.

Presence of Rabies in Region

If adequate laboratory and field records indicate that there is no rabies infection in a domestic species within a given region, local and state health officials are justified in considering this in making recommendations on antirabies treatment for bites by particular species. Such officials should be consulted for current interpretations.

MANAGEMENT OF BITING ANIMALS

A healthy domestic dog or cat that bites a person should be confined and observed by a veterinarian for 10 days. Any illness in the animal should be reported immediately to the local health department. If signs suggestive of rabies develop, the animal should be humanely killed and its head removed and shipped under refrigeration to a qualified laboratory designated by the local or state health department for examination. Stray or unwanted dogs or cats should be killed immediately and their heads submitted for rabies examination by fluorescent microscopy.

Signs of rabies in wild animals cannot be interpreted reliably; therefore, any wild animal that bites or scratches a person should be killed at once (without unnecessary damage to the head) and the brain examined for evidence of rabies.

If the brain is negative by fluorescent antibody examination for rabies, one can assume that the saliva contains no virus, and the bitten person need not be treated.

LOCAL TREATMENT OF WOUNDS

Immediate and thorough local treatment of all bite wounds and scratches is perhaps the most effective rabies preventive. Experimentally the incidence of rabies in animals can be markedly reduced with local therapy alone.

First-Aid Treatment to Be Carried Out Immediately

The wound should be thoroughly cleansed immediately with soap and water.

(Continued on page 147)

IOWA SUMMARY OF RABIES EXAMINATIONS 1964* THROUGH 1976—STATE HYGENIC LABORATORY AND IOWA VETERINARY DIAGNOSTIC LABORATORY

Species	Total Examined	Negative	Positive	
			(No.)	(%)
Alligator	1	1	0	0.0
Badger	35	32	3	8.6
Bat	1,319	1,262	57	4.3
Beaver	16	16	0	0.0
Bird	20	20	0	0.0
Cat	8,401	8,176	225	2.7
Chimp	1	1	0	0.0
Chinchilla	10	10	0	0.0
Chipmunk	206	206	0	0.0
Civet Cat	51	38	13	25.5
Coatimundi	2	2	0	0.0
Cow	3,072	2,455	617	20.1
Coyote	25	24	1	4.0
Deer	7	7	0	0.0
Dog	4,368	4,280	88	2.1
Donkey	1	1	0	0.0
Ferret	12	12	0	0.0
Fox	348	323	25	7.2
Gerbil	332	331	1†	0.3
Goat	16	16	0	0.0
Gopher	236	235	1	0.4
Groundhog (woodchuck)	149	147	2	1.3
Ground squirrel	404	404	0	0.0
Guinea fowl	1	1	0	0.0
Guinea pig	197	197	0	0.0
Hamster	1,773	1,771	2†	0.1
Hawk	6	6	0	0.0
Horse	266	237	29	10.9
Mice	1,994	1,994	0	0.0
Mink	77	76	1	1.3
Mole	219	219	0	0.0
Monkey	34	34	0	0.0
Moose	1	1	0	0.0
Mule	1	1	0	0.0
Muskrat	441	440	1	0.2
Ocelot	2	2	0	0.0
Opossum	444	444	0	0.0
Owl	7	7	0	0.0
Pig	294	283	11	3.7
Porcupine	1	1	0	0.0
Rabbit	857	857	0	0.0
Raccoon	1,799	1,787	12	0.7
Rat	740	740	0	0.0
Rodent	5	5	0	0.0
Sheep	143	136	7	4.9
Shrew	31	31	0	0.0
Skunk	2,612	1,153	1,459	55.9
Squirrel	2,363	2,363	0	0.0
Vole	10	10	0	0.0
Weasel	31	31	0	0.0
Unknown or unclassified	42	41	1	2.4
	33,423	30,867	2,556	7.7

* First full year during which fluorescent-antibody tests were done routinely in both laboratories.

† Infection caused by injection of LEP chick embryo vaccine. (Data source: W. J. Hausler, Jr., Ph.D., V. A. Seaton, D.V.M.)

TABLE I

POSTEXPOSURE ANTIRABIES TREATMENT GUIDE

[The following recommendations are only a guide. They should be applied in conjunction with knowledge of the animal species involved, circumstances of the bite or other exposure, vaccination status of the animal, and presence of rabies in the region.]

Species of Animal	Condition of Animal at Time of Attack	Treatment of Exposed Human
Wild		
Skunk	Regard as rabid	RIG + DEV ¹
Fox	Regard as rabid	RIG + DEV ¹
Coyote	Regard as rabid	RIG + DEV ¹
Raccoon	Regard as rabid	RIG + DEV ¹
Bat	Regard as rabid	RIG + DEV ¹
Domestic		
Dog	Healthy	None ²
and/or	Unknown (escaped)	RIG + DEV
Cat	Rabid or suspected rabid	RIG + DEV ¹
Other	Consider individually—See "Rationale of Treatment"	

1. Discontinue vaccine if fluorescent antibody (FA) tests of animal killed at time of attack are negative.

2. Begin RIG + DEV at first sign of rabies in biting dog or cat during holding period (10 days).

Treatment by or Under Direction of Physician

1. The wound should be thoroughly cleansed immediately with soap solution.

2. Tetanus prophylaxis and measures to control bacterial infection should be given as indicated.

POSTEXPOSURE PROPHYLAXIS

The following recommendations are intended as only a guide. They may be modified according to knowledge of the species of biting animal, circumstances surrounding the exposure incident, vaccination status of the animal, and presence of rabies in the region.

A combination of passive and active immunization (vaccine and immune globulin) is considered the best postexposure prophylaxis and is recommended both for treatment of ALL BITES by animals suspected of having rabies and for non-bite exposures inflicted by animals suspected of being rabid. Passive immunization should be used in conjunction with active immunization regardless of the interval between exposure and treatment.

Immunization

RIG and DEV: Passive antibody, RIG (ARS only if RIG is not available), is administered only once, at the beginning of antirabies therapy. The recommended dose of RIG is 20 IU/kg or approximately 9 IU/lb body weight. (When ARS

must be used, the recommended dose is 40 IU/kg, approximately 18 IU/lb or 1 vial of 1,000 IU/55 lb body weight.) Up to half the dose of RIG (or ARS) should be thoroughly infiltrated around the wound and the rest administered intramuscularly in the buttocks.

Twenty-three 1-ml doses of DEV should be given, beginning the day passive antibody is administered. Vaccine may be given as 21 daily doses or 14 doses in the first 7 days (2 injections each day) and then 7 daily doses. This should be followed by the 2 "booster" doses, the first booster 10 days after the 21st dose and the second booster 10 days later. Vaccine should be injected subcutaneously in the abdomen, lower back, or lateral aspect of the thigh; rotation of sites is recommended.

All persons who receive vaccine and RIG (or ARS) should have serum collected for rabies antibody testing at the time of the second booster. Testing for rabies antibody can be arranged by state health department laboratories. If no antibody is detected, additional boosters should be given.

Precautions

Since RIG (or ARS) partially suppresses active production of antibody, no more than the recommended dose of RIG (or ARS) should be given, and the 2 "booster" doses of vaccine must be given.

Local reactions to vaccine (DEV) are common and do not contraindicate continuing treatment.

When rabies vaccine must be given to a person with a history of hypersensitivity, especially to avian tissues, antihistamine drugs may be given. Epinephrine is indicated to counteract anaphylactoid reactions. If serious allergic manifestations preclude continuing prophylaxis with DEV, state health departments can advise physicians about possible use of experimental vaccines.

If neurologic reactions develop, vaccine treatment should be discontinued. Corticosteroids may interfere with development of active immunity and should be used only to treat life-threatening neuromuscular reactions when the possibility of clinical rabies has been ruled out. The Center for Disease Control, Bureau of Epidemiology, Viral Diseases Division, should be contacted for additional information on the differential diagnosis of rabies.

PREEXPOSURE PROPHYLAXIS

The relatively low frequency of severe reactions to DEV has made it practical to offer pre-exposure immunization to persons in high-risk

groups: veterinarians, animal handlers, certain laboratory workers, and persons—especially children—living in places where rabies is a constant threat. Others whose vocational or avocational pursuits bring them into contact with potentially rabid dogs, cats, foxes, skunks, or bats should also be considered for preexposure prophylaxis.

Two 1-ml injections of DEV given subcutaneously in the deltoid area 1 month apart should be followed by a dose 6-7 months after the second dose. This series of 3 injections can be expected to produce neutralizing antibody in 80%-90% of vaccinees.

For more rapid immunization, 3 injections of DEV, 1-ml each, should be given at weekly intervals with the fourth dose 3 months later. This schedule elicits an antibody response in about 80% of the vaccinees.

All who receive the preexposure vaccination should have serum collected for rabies antibody testing 3-4 weeks after the last injection. Testing for rabies antibody can be arranged by state health department laboratories. If no antibody is detected, booster doses should be given until a response is demonstrated. Persons with continuing exposure should receive boosters every 2 years.

When an immunized person with previously demonstrated rabies antibody is bitten by a rabid animal, he or she should receive 5 daily doses of vaccine plus a booster dose 20 days after the fifth dose. Passive immunization should not be given in this case; it might inhibit a rapid anamnestic response. For non-bite exposures, an immunized person with antibody needs only one 1-ml dose of vaccine. If the immune status of a previously

vaccinated person is not known, postexposure antirabies treatment may be necessary. In such cases, if antibody can be demonstrated in a serum sample collected before vaccine is given, treatment can be adjusted accordingly.

MANAGEMENT OF PERSONS WHO FAIL TO DEVELOP ANTIBODY FOLLOWING VACCINATION

Some individuals receiving postexposure or pre-exposure prophylaxis fail to develop demonstrable antibody after completion of the recommended regimens. Additional booster doses of DEV may produce the desired seroconversion. The patient's serum should be tested for antibody 2-3 weeks after each booster dose of DEV. If 2 additional booster doses of vaccine do not result in demonstrable antibody, authorities at the state health department or CDC should be consulted to determine if alternative procedures, such as the use of experimental vaccines, may be indicated.

ACCIDENTAL INOCULATION WITH LIVE RABIES VIRUS VACCINE

Persons exposed to Flury or the SAD (formerly ERA) vaccine should not be considered at risk, and antirabies prophylaxis is not indicated. There is no reliable information on which to judge the risk associated with accidental human exposure to new animal vaccines incorporating these strains in other substrates or to animal vaccines incorporating other rabies virus strains, and they should be regarded as potentially virulent for purposes of managing the treatment of exposed humans.

Source: Morbidity and Mortality Weekly Report, December 31, 1976/Vol. 25/No. 51.

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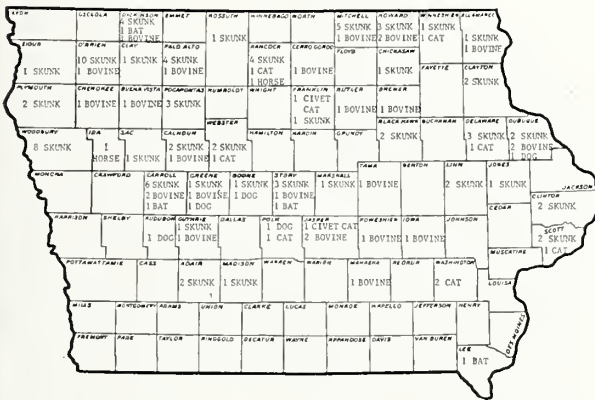
1976 ANIMAL RABIES IN IOWA

Diagnosed cases of rabies in animals increased 33% from the previous year to 134 cases. Skunks continue to head the list of rabid animals. This is probably a function of species susceptibility and population density. Next highest on the list is cattle, which are not routinely vaccinated for rabies and have extensive exposure to wildlife reservoirs, such as skunks. From an economic consideration alone, it may be worthwhile "insurance" to vaccinate highly valued or registered cattle. The public health implications of cattle rabies is not well defined. They are probably terminal hosts in the sense that cattle to cattle transmission has not been demonstrated. How-

ever, livestock men should exercise caution before exploring the oral cavity of ill cattle that are off feed and exhibit neurologic signs.

Cases of rabies in cats continue to outnumber those in dogs indicating the need for vaccinating pet felines as well as dogs. Available data again indicates that rabies occurs primarily in unvaccinated animals, suggesting the animal vaccines are efficacious if handled and administered properly.

Southwest and south central counties again continue to show an absence of rabies in all species. Ecologic factors accounting for this distribution remain unknown.



REPORTED CASES* OF RABIES IN ANIMALS IN IOWA IN 1976—COUNTY DISTRIBUTION BY SPECIES

Species	Cases
Skunk	88
Bovine	26
Cat	8
Dog	5
Civet Cat	2
Bat	3
Horse	2
Total	134

* Reported by State Hygienic Laboratory, Iowa City, and Veterinary Diagnostic Laboratory, Ames.

CONTINUING EDUCATION SERIES IN MAY

A continuing education series will be presented the week of May 9 in four Iowa communities by the University of Iowa College of Pharmacy. Intended for medical and osteopathic physicians and pharmacists, the series is entitled, "Clinical Pharmacy and Its Contributions to Improved Patient Treatment."

The two-hour evening conferences will occur as follows:

Monday, May 9—Atlantic
 Tuesday, May 10—Sioux City
 Wednesday, May 11—Webster City
 Thursday, May 12—Spencer

Speakers at each session will be Reuben B. Widmer, M.D., associate professor, Department of Family Practice, U. of I. College of Medicine, and Dennis Helling, Pharm.D., R.Ph., assistant professor of clinical pharmacy, U. of I. College of Medicine. A physician member of the Iowa Academy of Family Physicians and a pharmacist, both from the local community, will present remarks and will participate in a discussion period.

The 1977 spring series will duplicate a similar effort undertaken last fall in four other Iowa communities. Full details on the spring series will be mailed to all physicians in western Iowa in April.

ABOUT IOWA PHYSICIANS

Boone County Medical Society officers for 1977 are **Dr. R. A. Manderscheid**, president; **Dr. G. H. Sutton**, vice president; and **Dr. Louis R. Greco**, secretary-treasurer. All are Boone physicians. . . . **Dr. P. J. Leehey**, Independence physician for the past 44 years, was presented the 1976 Outstanding Resident Award by Independence Chamber of Commerce. Dr. Leehey was cited not only for devotion to patients but also for many other community services. . . . **Dr. J. V. Angel**, Council Bluffs, has been named president of the North Central Region of the American Association for Clinical Immunology and Allergy. . . . **Dr. Dilip Parikh** will begin the practice of surgery in Algona in July. Dr. Parikh received his medical

education in India; served a one-year internship at Michael Reese Hospital in Chicago; and five years in residency as follows—one year at General Hospital in Detroit; one year at Christ Hospital in Cincinnati, and three years at Iowa Methodist Hospital in Des Moines.

Dr. Martin S. Esders is closing his medical practice in DeWitt and relocating in Davenport where he will open an "office practice." Dr. Esders plans to refer all patients who require hospitalization to other Davenport physicians. . . . **Dr. John L. Parks**, Muscatine, was recently presented a plaque by Muscatine Chamber of Commerce for his work toward the establishment of the Muscatine Community Health Center, and for his efforts to expand the facilities at Muscatine General Hospital. Dr. Parks is president of the Muscatine County Medical Society.

DEATHS

Dr. E. J. Gottsch, 87, Shenandoah physician for 57 years, died February 15 at Hand Community Hospital. Dr. Gottsch received the M.D. degree at U. of I. College of Medicine; interned at Montreal General Hospital in Montreal, Canada, and completed residency in surgery at Winnipeg General Hospital in Winnipeg, Canada. Dr. Gottsch began his medical practice in Shenandoah in 1919. Following World War I, Dr. Gottsch, a WWI veteran, studied radium under famed physicist Madame Marie Curie in Paris. He was a member of American College of Surgeons and life member of the Iowa Medical Society.

Dr. Howard G. Ellis, 65, Des Moines, died February 10 at Mercy Hospital in Des Moines. Dr. Ellis received the M.D. degree at the University of Kansas Medical School and began his medical practice in Des Moines in 1938. He was a past president of the Mercy Hospital medical staff; past president of Iowa Clinical Surgical Society; member of American College of Surgeons; member of Iowa State Board of Medical Examiners;

and director of medical education at Mercy Hospital. The family suggests memorial contributions to the Mercy Hospital Foundation for Continuing Medical Education Fund.

Dr. Frank W. Reibold, 59, Carroll, died February 17 at his home. Dr. Reibold received the M.D. degree at University of Marquette Medical School; interned at St. Mary's Hospital in Madison, Wisconsin; and completed radiology residency at Butterworth Hospital in Grand Rapids, Michigan. Dr. Reibold began his practice of radiology in Carroll in 1958 and retired in 1974. He was a member of St. Anthony Hospital medical staff and Radiologist Society of North America.

Dr. Charles D. Fenton, 72, retired Bloomfield physician, died February 4 in Atlanta, Georgia. Dr. Fenton received the M.D. degree at U. of I. College of Medicine and interned at W. A. Foote Memorial Hospital in Jackson, Michigan. He began his practice of medicine in Bloomfield in 1932 and retired in 1973. Dr. Fenton was the Davis County coroner for many years and examining physician for county board of Selective Service for more than 20 years.

CONFERENCES FOR MEDICAL PROFESSIONALS

A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialties included. Send a \$10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

Medical Assistants



by BETTY EHLERT, CMA-A

1977 STATE CONVENTION APRIL 15-17

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During our national AAMA convention, in

the theme of the 1977 state meeting April 15, 16, 17 at the Sheraton Motor Inn in Mason City. (Complete program and registration information appeared in March issue of *IMS JOURNAL*.)

Chicago, several workshops awarded CEU's (Continuing Education Units), and this year, when we meet in San Francisco, there will be more opportunities to earn CEU's. We realize everyone cannot attend the national convention so programs on local and state levels will be geared to these requirements and approved for credit.

A new self-evaluation program has been developed by the AAMA Continuing Education Committee in collaboration with the Certifying Board, which provides a means whereby we can learn where we stand in relation to our colleagues in the field of medical assisting. This self-assessment program is designed for practicing medical assistants, employs the same format as the AAMA Certification Examination, and contains a self-scoring mechanism for your convenience. Cost is \$5 to AAMA members and \$8 to non-members.

How competent are you? You may need to know sooner than you think! by *Jeanne D. Green, CMA-A, AAMA President-Elect.*

DISTRICT EDUCATIONAL SEMINARS

Linn County Chapter of the American Association of Medical Assistants conducted an educational seminar February 19 at the Sheraton Inn in Cedar Rapids. Program topics included "Cardiovascular Surgery" by Montague Lawrence, M.D.; "V.D." by Franklin Koontz, Ph.D., of the State Hygienic Laboratory; "Cardiac Rehabilitation" by David Rater, M.D.; "Alcoholism and Drug Abuse" by William Bennett, M.D., and

"Neurosurgery" by Kazem Fathie, M.D.

Des Moines Chapter held an educational seminar on April 2 at Adventureland Inn. A film entitled "Autopsy Techniques and Restoration" was shown; Orlyn D. Englestad, M.D., spoke on "Cytology"; Rolando Creagh, M.D., presented "Endoscopic Retrograde Cholangio-Pancreatography"; Marge Clark discussed "Anatomy and Physiology," and a presentation on "Breast Self Examination" was made by the American Cancer Society.

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PHYSICIAN WANTED—Student Health Service Physician. Excellent University with attractive campus and performing arts center. Excellent fringe benefits. Salary negotiable. Contact L. Z. Furman, M.D., Student Health Service, Iowa State University, Ames, Iowa 50011. 515/294-5801.

FOR SALE—Well established dermatological practice for reasonable price of equipment. Sickness reason for retirement. Contact Herbert C. Leiter, M.D., 531 Badgerow Building, Sioux City, Iowa 51101. 712/255-3585.

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WANTED PHYSICIANS—ALL SPECIALTIES—As search consultants in the health care field, we are interested in physicians with a good career path for full-time positions as Medical Director, Assistant Medical Director, Chiefs of Clinical Departments, and clinical practice with our clients, blue-ribbon hospitals and other organizations in the health care field. We invite your curriculum vitae so that we may contact you when the right situation develops. No financial obligation to candidate. Contact LEPINOT ASSOCIATES INC., 702 ABBOTT ROAD, EAST LANSING, MICHIGAN 48823.

FOR SALE—Used extra examining room furniture and equipment, also, business machines and office furniture. Call 515/858-3612.

PSYCHIATRIC RESIDENCY: Vacancies for positions for July 1, 1977 for those who have a regular Iowa license or can obtain one by reciprocity or via the FLEX. Prepare for career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology Affiliation with University of Iowa. The Sti-

pends are: 1st Year \$21,294; 2d year \$22,360; 3d Year \$23,478. Intensity and diversity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call Collect 712-225-2594.

DIRECTOR, STUDENT HEALTH SERVICE—Iowa State University (enrollment 21,000). Full-time, 12 month appointment. M.D. required. Salary open. Send nomination or resume to Dean Wallace A. Russell, Search Committee Chairperson, 232 Carver Hall, Iowa State University, Ames, Iowa 50011. Application deadline May 1, 1977. An Equal Opportunity/Affirmative Action Employer.

FAMILY PRACTITIONER WANTED—To join 6-man group; newest city in Iowa; new hospital; well established group; production contract, short time to full partnership. Contact Ed Murphy, Carroll Medical Center, 502 N. Court, Carroll, Iowa 51401.

CEDAR RAPIDS, IOWA, SEEKS EMERGENCY PHYSICIAN—Full time. Join five others. Salary to start then full partnership if compatible. Start July 1, 1977. Approximately 30-40 hour week. Unique opportunity. For further information contact W. E. Kettelkamp, M.D., St. Luke's Methodist Hospital, 1026 A Avenue, N.E., Cedar Rapids, Iowa 52402. Phone 319/398-7211.

EMERGENCY ROOM PHYSICIAN WANTED—Keokuk, Iowa starting April. Percentage fee-for-service with guaranteed minimum of \$50,000 per year for two days work per week. Write No. 1525, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265, or call direct 415/435-0689.

MUSCATINE, IOWA—Needs 4 family physicians, 2 obstetricians, anesthesiologist, ophthalmologist, and otolaryngologist. Muscatine has a population of 23,000 and serves an area of 40,000. Construction has started on a new 4 million dollar addition to the hospital. Town is 30 miles from the University of Iowa and 30 miles from the Quad cities. 7 new physicians have located here in last 3 years and are continuing to make a determined effort to provide quality medical care to the community. If interested please send curriculum vitae and list of 4-5 references to David G. Kundel, M.D., Chairman, Recruitment Committee, 1501 Cedar Street, Muscatine, Iowa 52761.

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President's Page



The calendar has come full circle and here is May again. This is the month when the current proprietor of this page lays down his pen and his gavel and goes back to his patients, many of whom will wonder who that strange man is. I thank you for the honor and pleasure of serving you. I am grateful for the hospitality and graciousness shown Lenor and me as we journeyed about the state. Most of all, I am proud to have worked with such dedicated and perceptive people—officers, committees, members, and staff—who have brought strength and growth to the IMS. I shall always cherish the honor, the hospitality, and the dedication.

Bill Swanson and I have been friends and co-workers in the IMS for a long time. Even as you read this—if anybody does—he will be our new president and that fact comforts me. I pledge him my support and my willingness to carry any task he may assign me—but he already knows that. Let us all strengthen and nurture the IMS so it can further serve the people and physicians of Iowa. (How do you turn off one of these maudlin discourses? Just stop it, I guess.)

James F. Bishop, M.D.

James F. Bishop, M.D., President

P.S. Don't forget the Scientific Meeting at Telemark Lodge in northern Wisconsin, July 12-14, 1977.

IOWA Medical Miscellany

LEGISLATIVE UNCERTAINTY . . . Actions of the Iowa General Assembly, particularly of the House of Representatives, have been rapid and unpredictable in recent weeks. Move now is toward adjournment with observers indicating this will occur later in the month. House-passed legislation, as this is prepared, includes a measure to make permissible hospital employment of pathologists and radiologists; a bill to make certain immunizations mandatory for school entry; and a \$74 million Medicaid appropriation carrying with it provisions (a) for experimentation with a required second surgical opinion in elective Medicaid cases, and (b) payment restrictions for CAT scans. Measures to expand the chiropractic and optometric practice acts remain in committee at this time. Senate action on health-related matters has been more limited.

IMS/AETNA PROGRAM . . . Continuing efforts are being made to inform Society members about the new liability insurance program. Ten county meetings in March and April have provided opportunity for approximately 700 physicians to hear about the coverage. Evaluation is being made of any questions and concerns raised regarding the program. Classification inquiries have been most prominent and have resulted in some

modifications. For example, general practice physicians doing some obstetrics have been placed in Class II instead of Class III. Status of the total program was reviewed April 21 by the Medico-Legal Committee.

LIABILITY LEGISLATION . . . House File 179 received favorable consideration from the lower chamber in April. Now awaiting attention by the Senate, the multi-faceted House-passed bill allows (1) for periodic payment of judgments or awards above \$50,000, (2) for voluntary binding arbitration, (3) for breakdowns of verdicts, and (4) for strengthening of the board of medical examiners.

HEALTH PLANNING . . . Development of a Health Systems Plan is now the priority assignment of the Iowa Health Systems Agency (HSA). This required plan will address 15 different subject areas, e.g., emergency services, screening, problems of the elderly, acute care, etc. HSA technical committees are providing expertise as the plan is drafted.

COUNCIL MEETS . . . The Iowa Medical Assistance (Medicaid) Advisory Council met April 20 at IMS Headquarters to review the Title XIX program. The Council is made up of providers, legislators and consumers.

SUPER SETTING FOR IMS MEMBERS . . . Next big event on the 1977 Society calendar is the Scientific Session July 12, 13 and 14 at Telemark Lodge in scenic Cable, Wisconsin. Special rates will be in effect at Telemark Lodge for the full week as many Iowa physicians may wish to combine vacation with participation in the IMS scientific program. The three half-days of CME will include presentations on cardiology, endocrinology, caring for the pulmonary cripple, infectious disease, scope of family practice, even a speech training seminar. Full particulars have been included in several previous mailings. To obtain further information and registration forms, please contact IMS Headquarters (515/223-1401).



**SCIENTIFIC SESSION
JULY 12, 13, 14, 1977
TELEMARK LODGE
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The Question Box



by CATHERINE J. CONDON, M.D.

HOSPITAL MEDICAL EDUCATION

Catherine J. Condon, M.D., is Director of Medical Education at the Iowa Methodist Medical Center in Des Moines. She responds here to questions about postgraduate education at IMMC and in general.

How do you describe your duties as Director of Medical Education at a major Iowa Health care facility?

The duties of Director of Medical Education are quite varied but deal specifically with two programs: one involved with the three major residency programs presently in existence at Iowa Methodist Medical Center, including Primary Care Internal Medicine, Primary Care Pediatrics, and Surgery. I work together with the Directors of each of these programs to recruit faculty and resident applicants, review problems in the residency programs, review problems with individual residents, prepare applications for AMA approval as well as arrange site visits for renewed approval. Additionally, I try to answer questions and meet the demands of a private hospital involved in medical education. The second program is one involved with continuing medical education for the staff, a program that is increasing at the Medical Center and is expected to continue to increase. My office is attempting to identify the medical needs of the staff and address our CME programs to help meet those needs.

Can you give your brief assessment of the role of the community hospital in medical education?

There are those who believe the community hospital has no role in medical education, but I'm not one of those. The Universities are recognizing the need for training of young physicians in a setting more closely allied to that they will be ex-

periencing when in the practice of medicine. Additionally, the patient population, with its varied medical needs and demonstrating a wide spectrum of disease processes, is seen often-times better in a community hospital than in any university setting. Also the contact of students and residents with the private practitioner of medicine cannot be duplicated in a university setting.

The training of resident physicians in the primary medical care fields has received priority attention in recent years. Have the existing and emerging resident programs at Iowa Methodist been pressed forward in line with expressed physician manpower needs?

The reason I initially became interested in the position of Director of Medical Education at Iowa Methodist was the need I had seen in Des Moines for more doctors of general internal medicine and, to a similar degree, of general pediatricians. The initiation of the residency program in primary care internal medicine at IMMC was to meet the needs of the Des Moines community, as well as the communities in the State that need general internists badly; the attempt to strengthen the residency program in pediatrics at Blank Children's Hospital is for the same reason. The needs of Iowa communities for both primary pediatricians and internists is great. The real need for family practice physicians in Iowa has been given a great deal of publicity in last few years, particularly for the very small towns; the need for internists and pediatricians is not as well known but exists nonetheless, especially in the many cities and towns in Iowa that are not of the tiny variety but are of medium population. The programs at IMMC have been pushed forward to try to meet both of those needs (for general internists and pediatricians) as well as to meet the need for general surgeons in and around Iowa.

(Please turn to page 181)

State Department of Health

REYE'S SYNDROME (ACUTE ENCEPHALOPATHY AND FATTY DEGENERATION OF THE VISCERA)

At least five cases of Reye's syndrome have occurred in Iowa in recent months. Three deaths have occurred. Even though the etiology remains obscure, the syndrome is known to follow a viral infection with Influenza B one of the more common.

Reye's syndrome is a disorder of acute onset, usually one to several days after a viral upper respiratory infection or varicella, and characterized by manifestations of a diffuse, severe encephalopathy in addition to derangement of hepatic function. Coma, convulsions, and hepatomegaly are customary signs which frequently proceed to cardiorespiratory arrest and death within 48 to 72 hours after onset. Common but not invariable laboratory findings include hypoglycemia and decreased cerebrospinal fluid glucose, marked elevation in serum glutamic oxaloacetic transaminase and ammonia levels, and absence of cerebrospinal fluid pleocytosis. The pathologic findings are generalized brain swelling without cellular infiltration or other evidence of encephalitis, in addition to fatty degeneration of the liver and sometimes of the kidneys. Although the etiology and pathogenesis remain speculative, most investigators now feel that Reye's syndrome is best placed in the "post-viral" category and that the encephalopathy is in part secondary to hepatic dysfunction which results in hypoglycemia and increased blood levels of toxic substances, including ammonia.

The disease was recognized as an entity in 1963 by Reye, Morgan and Baral, although it had been described by previous authors as early as 1929.

While Reye's syndrome is not a reportable disease, the Iowa State Health Department is maintaining surveillance and asks assistance in reporting the disease. If a patient appears to have Reye's syndrome, it is recommended he be transferred immediately to a center where modalities of treatment and expertise can provide the necessary extremely complicated intensive care.

The following summary has been prepared by William Bell, M.D., professor of pediatrics and neurology, University of Iowa College of Medicine.

Greater awareness of the syndrome has made it apparent the disorder is not rare and variations of its severity occur. The disease has now been recognized in many parts of the world, affects either sex, and has been identified in children from two months to 16 years of age.

In this country, Reye's syndrome occurs either sporadically or in clusters, with several cases developing in a community over a limited period of time. The sporadic cases have followed varicella, a non-specific upper respiratory infection, or one in which a variety of viral agents have been isolated. Cases occurring in small outbreaks have more often been associated with antecedent influenza B infections.

CLINICAL MANIFESTATIONS

The history, physical findings and natural course of this disease are fairly uniform from patient to patient although mild forms of the illness can occur and are only identified by laboratory analysis. In such cases, the viral illness is followed by vomiting and perhaps transient headache or slight depression of awareness which progresses no further and is followed by uneventful recovery. The "usual" pattern with severe clinical manifestations is sufficiently common that clinical diagnosis can be virtually

certain within a few hours after hospital admission. Various forms of clinical staging have been proposed in an attempt to classify the degree of severity of the process at a given moment. The staging system of DeVivo et al includes Stage I manifested by vomiting, confusion, and lethargy. Stage II is comprised of symptoms of agitation, delirium, decorticate posturing, and sometimes hyperventilation. In Stage III, there is coma with decerebrate posturing, and Stage IV includes flaccidity, apnea, and dilated fixed pupils. The young infant with this illness may depart most from the customary pattern in that a prodromal illness may not have been recognized and the child, previously well, is abruptly found comatose or convulsing. Unless hepatomegaly is marked, the diagnosis may not be considered until post-mortem examination is accomplished.

Reye's syndrome in its common form is a biphasic disorder consisting of an initial mild viral illness, usually either as an upper respiratory infection or classical varicella. Following a latent period of one to several days, the second phase develops, most commonly in catastrophic fashion followed by subsequent deterioration of disturbing rapidity in many instances. Headache, profuse vomiting, lethargy or convulsions, are the initial manifestations of the encephalopathy which, within hours or a day or so, proceed to deep coma, sometimes associated with decerebrate rigidity. Irritability, delirium, and hyperexcitability are transiently present in some before deep coma supervenes. Recurrent vomiting at frequent intervals is such a notable feature during the early stages of the illness that its absence should raise doubt regarding the accuracy of the diagnosis. The respiratory pattern may be regular and slow or, more commonly, is characterized by rapid and labored breathing. Muscle tone often fluctuates between hypertonicity and hypotonicity during the progress of the condition. Neck rigidity or other signs of meningeal irritation are not expected unless part of the general posture of increased extensor rigidity. Fever may or may not be present, and in some, the illness is complicated by gastrointestinal bleeding.

Unless the process can be interrupted by prompt and judicious therapy, many cases will progress to death from respiratory or cardio-respiratory failure within a few days after onset. With recently proposed methods of therapy, the prognosis in Reye's syndrome perhaps is less dismal than earlier statistics suggest. Survivors

often recover completely but can be left with neurologic sequelae of invariable degree.

LABORATORY FINDINGS

The white blood count is often elevated in children with Reye's syndrome, commonly over 20,000 per cu mm. Acetone is present in the urine and dehydration may be reflected by elevation of blood urea nitrogen and increased serum osmolarity. In better than 50% of patients, hypoglycemia is documented in the early stages of the disease. Blood sugar may be as low as 5-10 mg% and is associated with a reduction in the cerebrospinal fluid glucose content. Hypoglycemia with this illness responds poorly to glucagon and has been shown to occur with low serum insulin levels, indicating that its origin is secondary to disturbed hepatic glucose production.

Biochemical evidence of hepatic dysfunction is now recognized to be a diagnostic hallmark of Reye's syndrome. Serum glutamic oxaloacetic transaminase levels vary from mildly to profoundly elevated, at times to levels of over 2,000 mg%. Despite this, serum bilirubin determinations remain normal or show only slight increases and jaundice is not commonly observed clinically. Among patients who survive, the serum transaminase levels return to normal within one to two weeks after onset of the illness and correlates well with rapid dissolution of fatty change within the liver. Serum free fatty acids have also been elevated in cases in which they have been measured. Serum ammonia elevation is another manifestation of hepatic injury which is found in Reye's syndrome and is believed by some to be one of the main factors provoking cerebral dysfunction. The degree of elevation of the blood ammonia is quite variable. In addition, the increase of the ammonia content may be very transient and can be missed if the determination is not done early in the course of the disease. Additional evidence of hepatic involvement in some patients includes abnormalities of clotting factors that are liver-dependent. A prolonged prothrombin time is usual with this illness and provides a rapid method of diagnostic testing, as compared to the serum transaminase determination which requires more time for laboratory analysis.

Cerebrospinal fluid examination is required in some cases to exclude the possibility of encephalitis or bacterial meningitis. Lumbar puncture is associated with considerable risk, however, when

brain swelling is advanced and intracranial pressure is markedly elevated. When the clinical pattern is strongly suggestive of Reye's syndrome, and the biochemical abnormalities support the diagnosis, lumbar puncture is best avoided because of the possibility of provoking internal herniation. The cerebrospinal fluid in Reye's syndrome contains few or no cells, a normal protein content, and a depressed glucose value in those who are hypoglycemic. In exceptional cases, a modest number of cells will be present and cannot be assumed to be incompatible with the diagnosis. The opening pressure can be normal or elevated, depending on the degree of cerebral swelling. The electroencephalogram reveals bilateral and diffuse slow abnormalities and may be of some predictive or prognostic value when studied in serial fashion.

ETIOLOGY AND PATHOGENESIS

Although the cause of Reye's syndrome remains in the speculative stage, continued epidemiologic, virologic, and biochemical investigations have begun to unravel at least some of the mysteries of the disorder. Exogenous toxins, viral agents, and genetic predisposition have each received etiologic consideration. The intoxication theory has received support from the experience in Thailand where investigators postulate the disease is caused by aflatoxin, a substance present in certain foods. Other observations suggesting a toxic origin have been the high frequency with which children with this illness have received salicylates, the discovery of isopropyl alcohol in tissues from one child with the disease, and the possibility of exposure of another to paint-thinner soon before onset of the syndrome.

In this country, a presumed etiologic association with viral illness has repeatedly been made and a number of different viral agents have been recovered. Geographically restricted outbreaks of influenza B virus infection have been associated with clusters of cases of Reye's syndrome. Varicella has been recognized by many observers to be the viral illness immediately preceding the disorder. Other viruses which have been recovered from various tissues in patients with Reye's syndrome include Cocksackie B, Echo, parainfluenza, Herpes simplex, and type-1 vaccine-like poliovirus. In only a few cases have viruses been isolated from brain tissue in patients with Reye's syndrome. The Epstein-Barr virus has also been

incriminated on the basis of serologic studies but without virus isolation. In addition, Reye's syndrome has followed simultaneous smallpox and typhoid immunizations and has been observed by the author in two siblings shortly after each received smallpox vaccine.

Yet to be answered is how the commonly observed preceding viral infection precipitates the organ system damage which comprises Reye's syndrome. The most popular current concept is that the primary brunt of the process is upon the liver with encephalopathy being mainly secondary to hypoglycemia, hyperammonemia, certain short-chain fatty acids, or other yet to be identified toxic substances resulting from hepatic insufficiency. It is generally agreed that this explanation may be an oversimplification and that Reye's syndrome may represent a response of liver and brain to a variety of different etiologic insults.

TREATMENT

The method and aggressiveness of treatment of Reye's syndrome is determined to some degree by the severity of the process when the patient is first seen and by the presence or absence, or rate, or progression of the clinical signs. Fluid and electrolyte abnormalities should be corrected with intravenous infusion of the appropriate fluids. Seizures are controlled with the use of intravenous diazepam but with constant attention to maintenance of an adequate airway and prevention of hypoxia and hypercapnea. Hypoglycemia requires immediate correction by glucose infusions and its recurrence can usually be prevented by continued use of 10% glucose solution. Hemorrhagic complications generally indicate coagulation defects secondary to hepatic-dependent clotting factors and are combated with vitamin K or with intravenous administration of fresh plasma when severe. Measures should be taken to prevent hyperthermia in this condition because of the increased cerebral metabolic requirements with temperature elevation. Salicylates should not be used in view of the uncertainty of their possible role in the pathogenesis of this disease. Cessation of oral intake and the oral administration of neomycin in dosage of 250-500 mg every six to eight hours is recommended in view of the uncertain but possible contribution of hepatic dysfunction in regard to neurologic signs.

The mildly affected child with Reye's syndrome manifested only by vomiting and lethargy should

(Please turn to page 178)



Educationally Speaking

by R. M. CAPLAN, M.D.

IS PURSUIT OF CME AN INSTINCT, IMPULSE OR HABIT?

In his stimulating series of essays, "Notes of a Biology-Watcher," Dr. Lewis Thomas recently made a strong statement of his belief about one aspect of man's nature. This statement asserts something fundamental to any theory about continuing medical education and why we engage in it: "Indeed, if there is any single attribute of human beings, apart from language, that distinguishes them from all other creatures on earth, it is their insatiable, uncontrollable drive to learn things and then to exchange the information with others of the species."

If he is right about the "uncontrollable drive," then it sounds as if he is describing an *instinct* ("an inborn pattern of activity or tendency to action common to a given biologic species; a natural or innate impulse or tendency"). It is instinct that leads bees to structure the complex architecture of their hive, or each variety of bird its unique type of nest, or migratory pattern. If CME were instinctual, we'd certainly not be having all these present discussions about making it mandatory, nor would there be a certain small to medium-

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

sized minority that does nothing, as it is alleged, that could be recognized as meaningful CME.

A word that suggests less predetermination is *impulse* ("an impelling action or force, driving onward or inducing motion"). If CME represented an impulse in us all, again there would be little discussion about requiring it of *Homo sapiens var. medicus*.

Perhaps the pursuit of CME is best characterized as *habit* ("customary practice or use; a dominant or regular disposition or tendency; an acquired behavior pattern regularly followed until it has become almost involuntary"). This word allows for the variation we see around us, with occasional individuals exhibiting practically none of the behavior under discussion, and others pursuing CME with an almost driven, panic-laden compulsiveness.

How much easier would be the life of a CME director if all our constituency operated out of instinct. And yet, I'm not sure I would choose that option if I could—it would have far too great a mindlessness about it to suit me. Rather would I strive for CME to be a habit, a very deeply ingrained one, that we follow almost compulsively, yet with full recognition that we are rational and making conscious choices among options. But then, exactly how do we best decide what activities would be most appropriate for us in our personal development, and for our patients' needs? Ah, that must be the subject of another essay.

CME ACCREDITATION

With appropriate ceremony, the Iowa Methodist Medical Center in Des Moines received in April a certificate of accreditation in continuing medical education from the Iowa Medical Society and the American Medical Association. The

certificate was presented by C. R. Aschoff, M.D., chairman of the IMS Committee on Medical Education and Hospitals, to Catherine Condon, M.D., IMMC Director of Medical Education. As an accredited agency, the CME programs of the IMMC are automatically eligible for Category I credit toward the AMA Physician's Recognition Award.

MEDICARE INACCURACIES PRODUCE FRUSTRATION

IN A RECENT SURVEY of Iowa physician leaders (presidents of county medical societies), the doctor respondents were asked to rank by importance 10 specific pressures bearing on them in their delivery of medical care. Not surprisingly, *governmental regulatory authority* headed the list.

More likely than not, this same response would have earned a top ranking from those in business, industry, the other professions, and probably the general public. The presence of government—in the regulatory sense—is becoming more and more oppressive—and more and more threatening, in the judgment of many perceptive analysts.

The survey response cited here emerged before national release in March of the names of 407 physicians who reportedly received more than \$100,000 from Medicare in 1975. This listing was issued by the Department of Health, Education and Welfare under the Freedom of Information Act.

Had release of these names come prior to the survey it might have precipitated an even greater aversionary response to the presence of government.

What makes this governmental release of monetary information particularly aggravating is the existence of so many erroneous figures. A study of 208 of the 407 physicians (listed as solo practitioners) who earned \$100,000 or more from Medicare revealed an error rate of 65%. Projecting this finding, if all of those listed had been contacted, the error rate would have been at least 33%. Of the 16 “top earners”—those identified by HEW as receiving more than \$250,000 from Medicare in 1975—the information was wrong in 14 cases.

The American Medical Association and the state medical societies contacted many of those whose names were contained on the HEW list. The information which turned up was disconcerting if not bizarre. One two-man clinic in Minnesota was noted as having received \$22.3 million. The amount should have been assigned to the Mayo Clinic. Another physician was listed as re-

ceiving \$102,731 as a solo practitioner in 1975, and he had been gone from the community noted since 1972. He's now part of a three-man group that received only \$1,800 from Medicare in 1975. The most common error in the HEW report was the identification of physicians as solo practitioners who actually are members of group practices, or in some cases, where permitted by law, are members of hospital staffs and receive fixed salaries.

In the listing of Iowa doctors, groups and clinics, as carried by the press, there were several instances where a single doctor's name was used to identify a group or clinic. In a conspicuously flagrant case of inaccuracy, one Iowa physician was shown to have received a sum in excess of \$700,000. In fact, he received only about \$15,000. He was credited with the total Medicare payments made to a major clinic of more than 40 doctors.

Moreover, while the Iowa physician in question moved to Pomona, California in 1975, many of his family remain here and received indirect criticism and abuse from the published listing. Comments were reported suggesting he made all that money and went to California. A front-page clarification was made following contacts by the physician with HEW and with the newspaper. Even this took considerable time and money and did little to lessen the distress and aggravation.

After receiving a barrage of protests, HEW admitted there were errors in the list and acknowledged those named had been subjected to criticism and distorted press reports. Reportedly, a new and correct compilation is being assembled but when it will be ready and how it will be distributed is unknown.

Illustrations such as this underscore why physicians—and others—respond as they do to surveys of the type mentioned at the outset of this discussion. With the possibility of this kind of inaccurate and misleading information waiting in the wings, it's not difficult to see why the conscientious physician is apprehensive about governmental intrusion.

IN THE PUBLIC INTEREST



SCIENTIFIC ARTICLES

Introduction to Whole Body CAT Scanning Of the Retroperitoneum

LEO MILLEMAN, M.D.,

GARY PEASLEY, M.D.,

LEE CHIU, M.D., and

DAVID CULP, M.D.

Iowa City

WHOLE BODY SCANNING by computerized tomography is a relatively new procedure. Its full capability will be more appreciated when results in clinical situations currently under way are more comprehensively reported. The purpose of this report is to introduce the practicing physician to the basic principles of this developing field and to allow him to become more familiar with CAT scanning terminology and potential usefulness. Case examples of retroperitoneal lesions are illustrated, as the retroperitoneum has been one of the first and most important fields to avail itself of the whole body CAT principle.

BACKGROUND

Initial research in computerized axial tomography involved both head and whole body tech-

Drs. Millemann, Peasley and Culp are associated with the Department of Urology, and Dr. Chiu with the Department of Radiology at The University of Iowa College of Medicine.

Whole body scanning is a new diagnostic concept. Its full potential must await analysis of the clinical applications now in process. Reported here are case examples of retroperitoneal lesions where scanning has been used.

nique. Due to complex problems in dealing with body organ movement, respiratory movement, and the broad range of tissue densities, the earlier refinements were concentrated on cranial tomography.

The basic groundwork for computerized axial tomography (CAT) or EMI scanning was described in 1961 by Oldendorf. Research culminating in the first cranial EMI scanner began in 1969 at the EMI Central Research Laboratories in Hoepe, Middlesex, England by G. W. Hounsfield. After an 18-month clinical trial, the first formal report of EMI scanning was given by Dr. James Ambrose to the Annual Congress of the British Institute of Radiology in April 1972. The first head CAT scanners in the United States were installed at the Mayo Clinic and Massachusetts General Hospital in 1973.

In simple clinical terms, the CAT scanner takes a series of horizontal slices (tomograms) with a highly collimated x-ray beam. Radiation expo-

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS
THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MAY 1977.

sure is confined to each slice and in cranial tomography 160 readings are taken over each slice. For brain scanning, 180 different slices are taken for a total of 160×180 or 28,800 different readings. The radiation reading is then stored on a magnetic tape as one of a possible 6,400 absorption values. The tape is played through a computer capable of transcribing each specific reading into a specific gray-black color density which is mapped out over the area scanned and recorded.

In cranial tomography, radiation dosage approximates that of a standard set of skull films.

The whole body scanner utilizes the same basic principles as cranial tomography, but particular measures have been added to adjust to problems of densities and organ movement. The cost outlay, radiation exposure, and time factor all currently prohibit the routine use of CAT scanning to cover the entire body from head to foot in one setting.

FUNCTIONAL PRINCIPLES

The components of the whole body scanning unit include the x-ray tube, photocopier, patients'



Figure 1. CAT scan unit and control console.

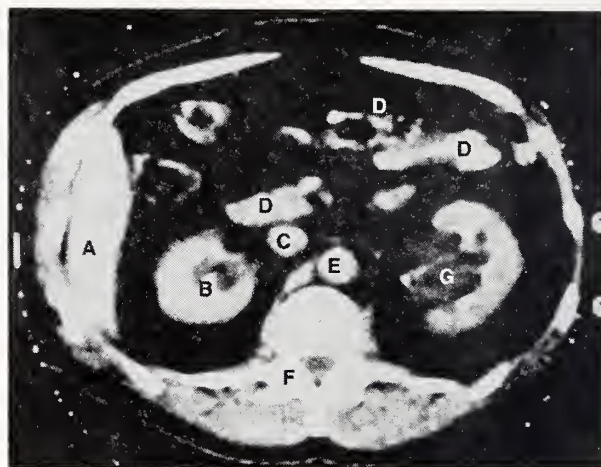


Figure 2. Peripelvic lipomatosis. L-2 level. A—Liver; B—Contrast in collecting system; C—Inferior vena cava; D—Small bowel; E—Aorta; F—L-2 vertebra; G—Peripelvic lesion.

couch and the key board. Housed in another room are the computer, electronic units, control console and line printer (Figure 1).

The whole body scanning unit examines 13mm slices per cut, but may be adjusted in some cases to 8mm. A complete tomographic cut takes 20 seconds during which time the patient must remain motionless and hold his breath. Thirty well-aligned and accurate sensitive "x-ray" detectors are located surrounding the scanning frame. X-rays traverse the patient in one second's time and its relative absorptive value is recorded by the detectors as one of more than 18,000 values. The traverse is then rotated 10 degrees and another one-second scan is performed. This process is repeated 18 times until 180 degrees are covered. During this 20-second period over 300,000 absorptive values are recorded, processed by the computer and printed out on a grid or stored on magnetic tape. Dosage and absorption print-out data may be adjusted by the technician to compare read-outs with known tissue densities such as water, fat, and bone.

ANALYSIS

The 20-second cycle is a reasonable time for a patient to hold his breath. Movement may cause artifact. The 300,000 absorptive values taken during a scan give spatial resolution of each element equal to $.75\text{mm} \times .75\text{mm}$. This is an area roughly equivalent to that of a standard pin head. The stored magnetic tape may be replayed at a later time or a standard Polaroid photograph of the printed grid may be exposed for inclusion in the chart record.

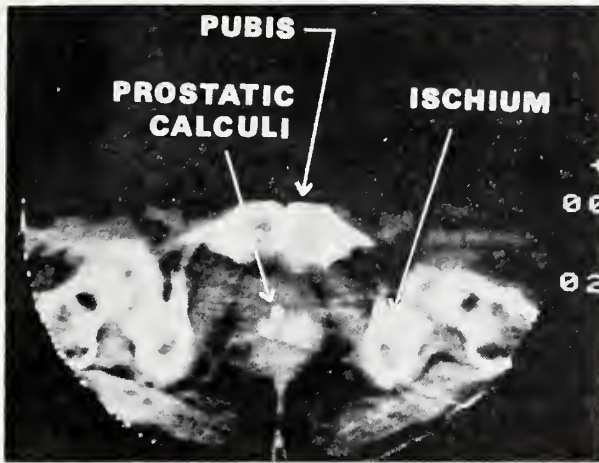


Figure 3a. Prostatic calculi: 1.5 cm above symphysis pubis.

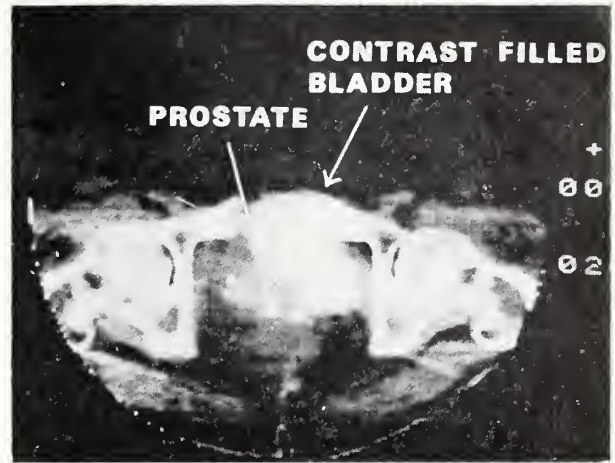


Figure 3b. Prostatic calculi: 2.6 cm above symphysis pubis. Note distortion of bladder by intravesical prostate.

The following case examples illustrate the described principles. The whole body CAT scan provided major adjunctive diagnostic information.

Case 1. L. T. This 54-year-old male presented to the urology clinic with microscopic hematuria. An intravenous pyelogram revealed an abnormality of the left kidney. Cystoscopy, cytologies and selective renal arteriography were within normal limits. A CAT scan revealed a peripelvic lesion diagnosed as peripelvic lipomatosis. The patient's hematuria cleared after antibiotic treatment for prostatitis (Figure 2).

Case 2. A. P. This 66-year-old male presented with urinary retention. Past medical history was interesting in that he had had an A-P resection for adenocarcinoma of the colon two years previously. The oversewn rectum made rectal examination impossible. Intravenous pyelogram, cystogram and baseline laboratory data were unre-

markable. A pelvic computerized tomogram was performed utilizing the indwelling catheter for a coordinated cystogram. Two cuts are illustrated.

A TURP of 23 gm was performed with the finding of prostatic calculi and benign prostatic tissue pathologically (Figure 3).

Case 3. J. B. A 14-year-old male presented to the emergency room following an automobile accident. Ecchymoses were noted over the right

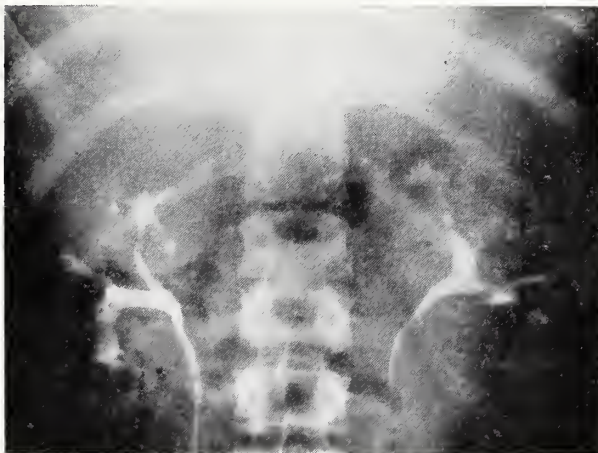


Figure 4a. IVP: Note distortion of left lower pole.

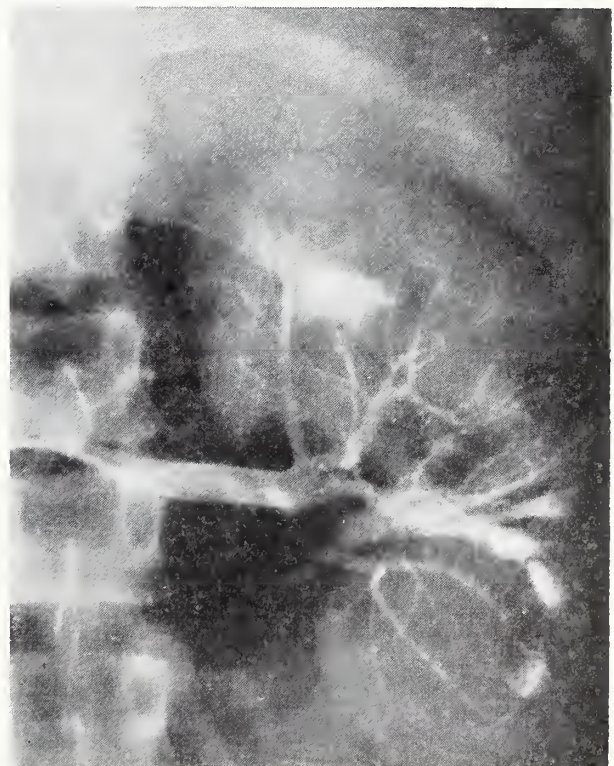


Figure 4b. Arteriogram.

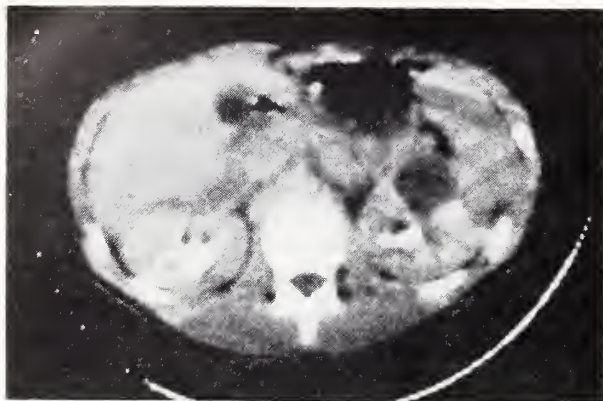


Figure 4c. Left renal cyst.

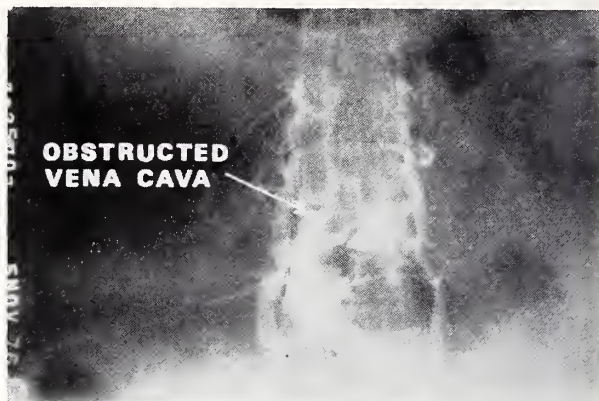


Figure 6a. Inferior vena cavagram revealing obstruction.

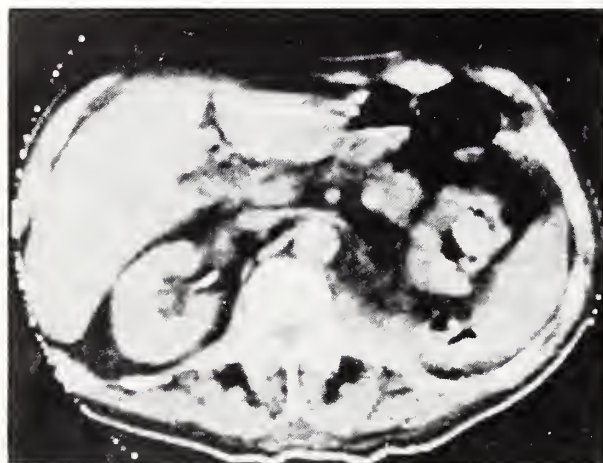


Figure 5a. CAT scan 4 cm below xiphoid; solitary kidney.

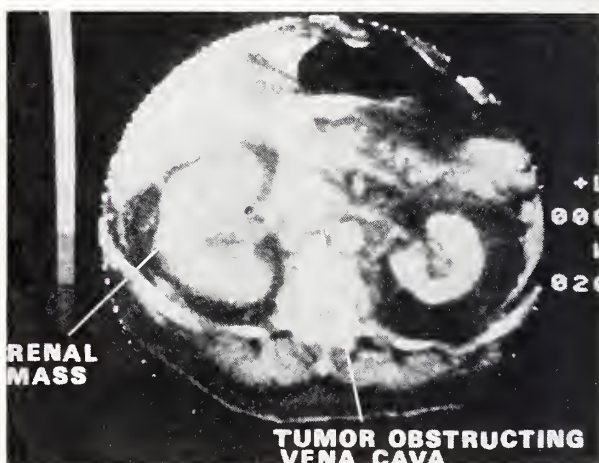


Figure 6b. CAT scan showing tumor obstructed vena cava.



Figure 5b. CAT scan 6 cm below xiphoid; large left sided mass.

flank. Previous medical history was unremarkable. An intravenous pyelogram revealed an intrarenal mass displacing the left kidney laterally. Ultrasound, arteriography, and CAT scanning

confirmed the presence of a benign peripelvic renal cyst. Comparative illustrations are sighted (Figure 4).

Case 4. E. H. This 60-year-old male presented to the orthopedic department with severe left leg pain. Two years previously the patient had had a left radical nephrectomy for hypernephroma. Baseline blood chemistries were normal. An intravenous pyelogram revealed a normal solitary kidney. A CAT scan revealed a retroperitoneal mass of the left flank. A retroperitoneal study confirmed recurrent hypernephroma (Figure 5).

Case 5. I. S. This 69-year-old female presented for evaluation of a large upper abdominal mass. An arteriogram revealed a large vascular neoplasm of the right kidney with involvement of the vascular pedicle. An inferior vena cavogram revealed complete obstruction of the inferior vena cava at the level of L-4 with massively dilated lumbar veins bilaterally compatible with a large

infiltrating hypernephroma. Comparative studies are illustrated (Figure 6).

Computerized axial tomography has added another dimension to diagnostic medicine. It does not replace standard roentgenology, but does add useful adjunctive information. In some cases CAT scanning has been the only method available to establish the presence of a retroperitoneal lesion.

Its usefulness in other areas, and as a monitor for treatment responses to various solid tumor regimens, are currently being studied.

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Timing of Surgery In the Child With Cleft Lip and Palate

GEORGE B. IRONS, M.D.

Rochester, Minnesota

The timing of surgery in the child with cleft lip and palate should proceed along a definite schedule. The use of a team approach should be considered with conservatism followed in surgery. A summary of the schedule is provided.

THE TIMING OF SURGERY for the child with cleft lip and palate deserves careful consideration. This timing may affect the outcome, and thus the child's appearance and function. And, a poor outcome may be difficult to correct. This paper outlines a schedule for the management of the cleft child, which has been found to be effective at the Mayo Clinic.

The main problems in the management of the child with cleft lip and palate can be classified as either cosmetic or functional. Cosmetic problems involve the lip, nose, teeth, and the middle of the face. The lip is cleft and shortened and has no cupid's bow and no philtral column on the cleft

side. The nose has a flattened alar arch, flared alar base, and wide nostril floor, and the normal side is twisted. In addition, with a double cleft, the columella is shortened. The teeth may be crooked, missing, or maloccluded. The middle of the face may be hypoplastic.

Functional problems are related to speech, hearing, and eating. Speech problems may be due to a cleft, oral-nasal fistula, short palate, or malpositioned teeth. These conditions can cause errors in articulation, hypernasality, and nasal escape. Many functional problems are due to malfunction of the eustachian tube secondary to the abnormal insertion of the levator palati muscles in patients with a cleft of the palate. This malfunction can cause fluid collection in the middle ear, which results in impaired hearing and an increased incidence of ear infections. Eating problems are relatively minor, but are related to difficulty in sucking and leakage into the nose when the palate is cleft.

In addition to these problems with the child, there may be problems with the parents. They may have feelings of disappointment, guilt, or helplessness. They need counseling regarding their role in the management of this defect.

In most teaching institutions, the cleft child is managed by a multidisciplinary team. The team functions (1) to chart a long-term general plan, (2) to follow the patient's development, and (3)

This paper was presented to the Iowa Academy of Family Physicians, Des Moines, Iowa, on September 25, 1975. The author is associated with the Mayo Clinic and the Mayo Foundation.

to solve problems as they arise for each child. Members of the team include the plastic surgeon, the otolaryngologist, the orthodontist, the prosthodontist, the speech pathologist, the social worker, and the clinical psychologist. Recommendations are made to the child's parents and to his family physician.

The timing of surgical procedures is decided by the cleft team on an individual basis, but a general plan is followed. When the child is 3 months old, the cleft lip is repaired. We wait 3 months because anesthesia is safer at this age than it is in the newborn, surgery is easier inasmuch as the structures are larger, other congenital defects usually can be detected by this time, and the family will have a chance to appreciate the problem better.

At 18 months, the soft palate is repaired. This repair provides an anatomic closure of the cleft and a normal speech mechanism without interfering with facial bone growth. We favor the simplest repair possible. At times, this can be done by simply freshening the cleft margins and suturing them together. Usually, small relaxing incisions on each side laterally are necessary.

Between 4 and 8 years, the hard palate is repaired. Most of the lateral growth has been completed by this time so there is minimal risk that the surgery will retard or distort growth of the maxilla.¹ If closure is done before this age, about half of the patients will have some abnormality of the maxilla, such as medial collapse of the alveolar arch, crossbite, or maxillary hypoplasia. A conservative approach to closure of the hard palate is indicated²⁻⁷ because of the growth abnormalities produced by early closure of the hard palate, because growth of the middle of the face seems to proceed relatively normally in patients with unrepaired clefts, and because many of

these clefts will virtually close spontaneously with time.

After the child is 4 years of age, further surgery for cosmetic and functional improvement may become necessary. The columella may require lengthening, and the ala on the cleft side may need to be repositioned for symmetry. Revisory surgery on the lip may be indicated to correct discrepancies in the vermilion margin, a cupid's bow that is too high or too low, a notch in the lip, a whistle deformity, or a prolabium that is too wide. About 30% of the patients with cleft palates will need a pharyngeal flap to correct palato-pharyngeal insufficiency. In this procedure, a flap of posterior pharynx based superiorly is elevated and attached to the soft palate to correct the problems of hypernasality and nasal emission.

Bony procedures are generally delayed until after the child is 16 years old or after normal growth has been completed. Procedures such as rhinoplasty, maxillary advancement, and mandibular setback are not considered until after this age. Other surgical procedures, such as a myringotomy, are not related to age but are done whenever necessary.

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AUTHOR NEW TEXT

AMA Past-President Donovan F. Ward, M.D., Dubuque, is the co-author of an updated 642-page book published by William C. Brown Company and entitled *Effective Medical Assisting*. Dr.

Ward's co-author is Shirley Pratt Schwarzrock, Ph.D., assistant professor, University of Minnesota.

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Intramural Hematoma of the Duodenum: A Case Report

MARK W. REINERTSON, D.O.

Des Moines

The author presents a case of an intramural hematoma of the duodenum which mimicked an acute abdomen in its presentation and was initially a diagnostic dilemma.

ALTHOUGH RARE, the possibility of an intramural hematoma of the duodenum should not be overlooked in the differential diagnosis of abdominal disorders. Usually the result of blunt trauma to the abdomen, duodenal hematomas have been sporadically reported in the literature since the first documentation by McLachlan in 1938. His paper described a false aneurysm of the duodenal wall in an adult.¹

Such hematomas generally present with findings of high bowel obstruction. Diagnosis may be confirmed by upper gastrointestinal contrast studies which demonstrate an intraluminal duodenal mass with the pathognomonic "coil spring" sign of the mucosa overlying it.² (Figure 1)

CASE HISTORY

MW is a 2½ year old white male whose past medical and family history were noncontributory. His present illness began five days prior to admission. At that time he developed symptoms of an upper respiratory infection. Two days prior to admission he began vomiting—as many as ten times per day. He was afebrile. One day prior to admission he became restless and vomiting persisted. An antiemetic rectal suppository was tried without success. He also began to complain of

a "dull" abdominal pain, and was admitted to a local hospital. W.B.C. at that time was 15,000 cells/cc. of which 62% were polymorphonuclear cells and 38% were lymphocytes. He began to vomit brownish material and was transferred to Blank Memorial Hospital for Children for further evaluation. There was no history of apparent trauma obtained on admission, but on persistent questioning at a later time the parents did remember a seemingly insignificant blow to his abdomen 3-4 days prior to admission.

Physical exam revealed a lethargic, pale child in considerable distress. Temperature was 101°F., pulse 184/minute and respirations 24/minute. Positive physical findings were limited to the abdomen. Bowel sounds were hyperactive. There was no distension. Tenderness was elicited on superficial and deep palpation, and a tender mass was palpable in the right flank. There was diffuse nonvoluntary guarding thought to be greater on the right side than the left. No bruising was noted, nor was there other evidence of trauma. Hydration was fair. Neurologic exam was grossly normal at the time of admission.

LABORATORY FINDINGS

Pertinent laboratory information obtained on admission included: WBC 16,200 with 52% polys and 31% lymphocytes. Hemoglobin was 10.1 gm%, Hematocrit 29.5%. The urinalysis was negative. Cultures of the stool, throat, blood and urine were all negative for pathogens. Chest X-ray was interpreted as normal. Electrolytes, blood urea nitrogen, and serum glucose were normal.

At this point in the differential diagnosis intussusception was considered most likely, and a colon X-ray with contrast material was obtained. Findings were consistent with an intussusception with the most distal end of the intussusciptiens at the level of the proximal transverse colon.

The author is a resident in pediatrics at Raymond Blank Memorial Hospital for Children in Des Moines, Iowa.



Figure 1. Shows the "coil spring" sign of the mucosa overlying the intra-intraluminal duodenal mass.

However, it would not reduce under fluoroscopy, and the patient was taken to surgery.

At surgery an intramural hematoma of the duodenum was found which had ruptured and caused extensive hemorrhage into the mesentery of the small bowel and right transverse colon. These findings were later visualized on X-ray with an upper gastrointestinal series. (Figure 2) The hematoma was decompressed but not evacuated, and the patient was treated medically. Treatment included naso-gastric suction and intra-

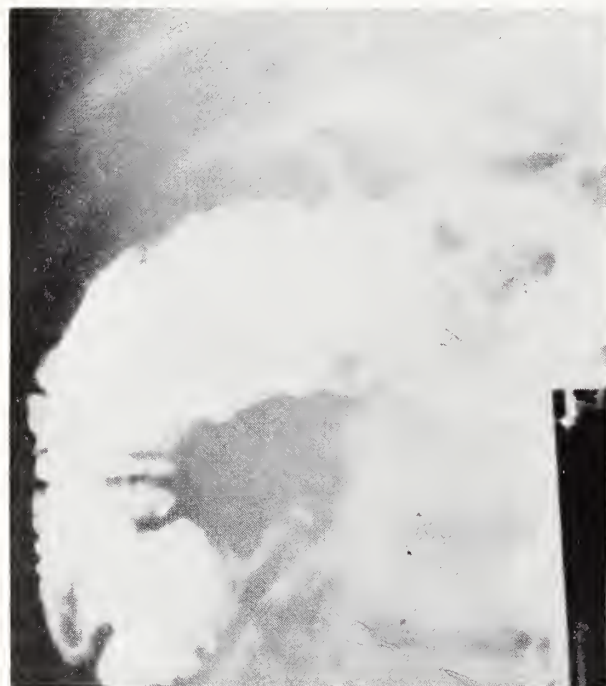


Figure 2. Shows the intraluminal mass in the duodenum with contrast material in large bowel from previous examination.

venous fluids administered via peripheral venous line. By the eighth post-operative day, he was started on oral fluids and was discharged two weeks after admission.

An intramural hematoma, such as found in our patient, may be the initial presenting sign in a "battered child syndrome."³ It may be the result of a minor blow to the abdomen. They have been found associated with anticoagulant therapy, blood dyscrasias, pancreatic disease, severe hiccoughs, epilepsy, mesenteric adenitis, and Henoch-Schoenlein purpura. Whatever the cause, the duodenum seems to be the most common area of involvement, especially in youngsters. This is probably a result of the relatively fixed retroperitoneal position of the duodenum near the spine, not allowing it to effectively absorb the trauma involved.

Another theory suggests that the hematoma may originate in the small subserosal vessels, along the mesenteric border of the intestine, which have been subjected to a shearing force at the time of injury.

DIFFERENTIAL DIAGNOSIS DIFFICULT

The classical history of an intramural hematoma as reported by W. R. Jones, *et al*, describes a child with minor abdominal trauma 3-4 days prior to admission, who develops intractable vomiting 24-48 hours after the injury.⁴ He states that a history of low-grade fever may be obtained, and dehydration is usually present to some degree. A high percentage of these patients present with signs and symptoms of intestinal obstruction and a history of abdominal pain is always elicited.

Physical examination, according to Jones, reveals a lethargic, dehydrated child, with definite abdominal tenderness, and frequently a tender abdominal mass in the area of the hematoma may be palpated. There is usually no abdominal distension and bowel sounds are normal. Abdominal guarding is usually present.

Obviously, from the foregoing description, and because of the oftentimes vague history elicited from the parents, the differential diagnosis in such a patient may be difficult. It includes intestinal intussusception, ruptured viscus, acute appendicitis, other abdominal masses, pancreatitis, peritonitis, rectus hematoma, duplication of bowel, annular pancreas, cholecystitis, to mention a few.

Definitive diagnosis is aided by a combination

of a high index of suspicion, as well as, the clinical and radiologic findings. Diagnosis is confirmed, ideally, radiologically. Plain films of the abdomen may show abdominal distention and paucity of gas in the intestinal tract consistent with an obstruction. The psoas shadows may show obliteration of a segment of one or both in their upper portions. One may see an abdominal mass. Barium contrast roentgenograms will show an intraluminal filling defect in the duodenum, and the characteristic "coil-spring" sign.²

Once the diagnosis is made, the consensus regarding management seems to favor the conservative approach.^{5,6} Nasogastric suction and intravenously administered fluids should be attempted in all patients whose clinical condition remains stable. Surgical intervention should be reserved for those patients with evidence of perforation, intraperitoneal hemorrhage, shock, ruptured viscus, or those in which an appropriate trial of conservative treatment (10-14 days) has been unsuccessful.

SUMMARY

A case of intramural hematoma of the duo-

denum is presented in which the correct diagnosis was not made preoperatively. The pathophysiology, diagnosis, differential diagnosis and management are briefly reviewed. We are pleased to report that our patient made an uneventful recovery and is now in his usual state of good health.

ACKNOWLEDGEMENT

A special thanks to Lee Forrest Hill, M.D., for his contribution in the preparation of this case report for publication. Thanks also to Jack Spevak, M.D., and James Hopkins, M.D., for their contribution in making this case, as usual, a learning experience.

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STATE DEPARTMENT OF HEALTH

(Continued from page 166)

be managed with the above-described considerations but closely watched at frequent intervals for progression of the illness. Some degree of fluid restriction would be appropriate, even at this stage, with the hope of forestalling the occurrence of or progression of cerebral edema.

The more seriously ill child with deep lethargy or coma, decorticate or decerebrate posturing, hyperventilation, or pupillary abnormalities can be expected to deteriorate rapidly unless managed intensively. In the past, therapy for this condition was designed with the concept that the encephalopathy was primarily the result of hepatic failure and thus included methods to eliminate toxic materials from the vascular compartment. Peritoneal dialysis was favored by some with variable results but with evidence of improvement of the mortality rate in certain reports. Others resorted to exchange transfusions with fresh heparinized blood, likewise with improved outcomes in some series. The mode of action by which exchange transfusion possibly brings about improvement in this disorder remains unclear. One effect of exchange transfusion is the lowering of the level of intracranial hypertension and it is possible that improvement is explained on this basis. The mechanism by which exchange transfusion reduces intracranial pressure, however, remains unclear.

It is now generally believed by most investigators that the principal cause of death in Reye's syndrome is not hepatic failure but is the result of massive and rapidly progressive brain swelling with subsequent internal herniation. The recognition of the importance of brain swelling and increased intracranial pressure in this disorder has led to the use of intensive regimens to control intracranial pressure with significant improvement in mortality resulting. For such measures to be effective, it is necessary that treatment be initiated before the child reaches advanced stages of the disease in which the pupils are dilated and fixed and the limbs have become flaccid and without reflexes.

Vigorous antiedema therapy should be instituted when it is clear that the illness is progressing and has advanced beyond Stage I. Restriction of intravenous fluid administration will enhance the effects of agents used to reduce cerebral edema. Unless clinical signs of dehydration are

severe, fluids can be restricted to approximately 50% of maintenance requirements. Dexamethasone in dosage of 0.5 milligrams per kilogram per day (up to 40 kilograms of body weight) is used in combination with mannitol in dosage of 1.5 gm per kg given intravenously over a period of 20 to 30 minutes. How frequently to repeat mannitol infusions and how long and to what degree to continue fluid restriction is difficult to judge clinically but is a critical factor in regard to the hour by hour management. Decisions are best made on the basis of the level of intracranial pressure but this is not always clearly reflected from the clinical signs. The use of one of the recently developed methods of continuous intracranial pressure monitoring provides an accurate estimate of intracranial pressure at frequent intervals and can be maintained for three to six days if necessary. With the subdural or epidural screw in place, acute rises in pressure can be combated with hyperventilation, followed by periodic infusions of mannitol at intervals of four to six hours. With such aggressive dehydrating and antiedema therapy, it is important to check periodically the urine output, blood urea nitrogen and creatinine, serum glucose and electrolytes, and the serum osmolality. Dehydration in many cases should be sufficient enough to raise the serum osmolality to between 310-330 mOsm per liter. An indwelling catheter is required to prevent overdistention of the bladder, and a central venous line is used to monitor central venous pressure which is maintained at between 5 and 10 cm of water. When intracranial pressure monitoring reveals that intracranial hypertension has subsided, intravenous fluid administration is increased in volume and further mannitol infusions are withheld.

The above regimen is most efficiently accomplished in an area of intensive care, and with endotracheal intubation and respiratory support as required. A vitally important aspect of management is ventilatory control so that episodes of hypoxia and hypercapnea are prevented. In unusual cases, the intracranial pressure is not found to be significantly elevated, despite marked obtundation and other abnormal neurologic signs. In an occasional child with Reye's syndrome, brain swelling proves to be intractable to the above methods of treatment. Exchange transfusion can be beneficial when intracranial pressure remains high, or curarization with hypothermia may be effective when other measures have failed.

(Please turn to page 181)



Editorials

M. E. ALBERTS, M.D., Scientific Editor

A LEARNED PROFESSION

Do you consider yourself a member of a learned profession, or are you a captive of modern technology? In a provocative lecture to the Royal Society of Medicine, Professor Sir George Pickering queried: "Medicine at the crossroads: learned profession or technical trades union?" The question is as appropriate in the United States as in England. In Pickering's opinion, medicine is in danger of devaluing learning. A deeper meaning of learning is the ability to convey to others by speech and writing a great variety of facts, thoughts, and ideas with clarity and precision. The learned man must be able to speak and write so he can be understood.

In ages past, a profound knowledge of Latin and Greek distinguished the learned profession from other vocations. Latin was the medium of communication. Even today, many universities provide a certificate written in Latin to the recipient of a professional degree. The formal awarding of degrees in Oxford and Cambridge is done in Latin. One wonders how many students understand what is being said to them at so important a time in their lives.

Unprofessional behavior seems to be not only

tolerated now, but encouraged by larger organizations of both older and younger doctors. The art of medicine consists of understanding the individual patient. Fundamental to this is the need to listen. Herein lies the initial premise of a learned professional—an understanding of language; an ability to understand and to be understood. A precise word, a description of a thought, takes time and effort. Our profession often forgets this. Listen to the younger ones, and to the "hep" older physicians. There is not the fine descriptive language, often only a jumbled maze of letters which are knowledgable supposedly to all, e.g., SOB, CXR, PX, etc. It is appalling the number of manuscripts we receive which include "meaningless" abbreviations. The paper could be so much more meaningful if a good mastery of language was possessed by the writer.

Physicians must avoid being tools of technologic advances. We still deal with people. Patients are not numbers. They have life and breath. They must be understood and they must be able to understand us. Let us not get caught up in a race to profit at the expense of the public. Ours is a dedicated learned profession for which history has shown the highest respect. In the manner that Sir George Pickering completed his lecture, we must ask the same question: "*Ought we not be ashamed if we hand on a tarnished image to our successors?*"—M.E.A.

Pickering, Sir George: Medicine at crossroads: Learned profession or technological trades union; Proc. Roy. Soc. Med. 70:16-20, 1977.

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Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

See next page for brief summary.

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Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

STORE BETWEEN 59° and 86°F (15° and 30°C).

Full information is available on request.

STATE DEPARTMENT OF HEALTH

(Continued from page 178)

In the child with Reye's syndrome of moderate degree or worse and with progressive signs, the author's current preference for therapy, in collaboration with the surgical intensive care unit, is an aggressive approach utilizing curare, endotracheal intubation, and hypothermia. Pulmonary wedge pressure is continuously measured with a Swan-Ganz catheter, and intracranial pressure is monitored with a subdural screw. The degree of fluid restriction is determined by laboratory parameters and central pressure recordings. Mannitol is administered intravenously as needed to control intracranial hypertension, but this has been infrequently required once hypothermia has been achieved. Hypothermia is maintained for 48 to 72 hours, with rewarming of the patient being determined on the basis of results of SGOT determinations and serial EEG results. Using this approach, the significant decline in mortality has been appreciated, compared to a previous therapeutic method which included more conservative measures.—*William E. Bell, M.D., Section of Pediatric Neurology, Departments of Pediatrics and Neurology, University Hospitals, Iowa City.*

QUESTION BOX

(Continued from page 163)

What about CME for practicing physicians? Is the hospital—with organization from the medical staff—the best setting in which to provide most continuing medical education?

I am not certain there is any "best setting" in which to provide continuing medical education. I have seen continuing medical education provided well in several different settings. I do believe the hospital, with organizational assistance from its medical staff, utilizing the same teaching staff and programs that are available because there are residency programs to be taught, lends itself to provide continuing medical education for the private practicing physician as well. Conferences, seminars, etc., can be set up that will supply the need for resident education as well as for education of the practicing physician and vice versa, often-time utilizing the same speakers, the same conference rooms, the same audio visual equipment, etc. So that while I am not certain there is a "best setting" for providing continual medical education, I believe it can be done *well* in a hospital setting such as ours.

About IOWA Physicians

Dr. Marvin Silk is medical staff president at Mercy Hospital in Des Moines; **Dr. Byron Augspurger** is president-elect; and **Dr. Robert Jones** is secretary-treasurer. All are Des Moines physicians. . . . **Dr. Franklin C. Perkins**, Hedrick physician for 48 years, retired March 15. Dr. Perkins received the M.D. degree at U. of I. College of Medicine. Prior to locating in Hedrick, he served one-year in the Department of Neurology at the University. **Drs. Opas and Puangtong Jutabha**, Sigourney, will assume Dr. Perkins' practice. . . . **Dr. Robert E. Shaw**, Waverly, has been honored with a lifetime membership on Bremer County Board of Health. Dr. Shaw recently completed 12 years on the board. . . . **Dr. Hugh C. Dick**, urologist, has joined the Kersten Clinic in Fort Dodge. Dr. Dick received the M.D. degree at University of Kansas Medical School, and completed residencies in urology and surgery at Baylor University in Houston, Texas. Prior to locating in Fort Dodge, Dr. Dick practiced in Colorado Springs, Colorado. . . . **Dr. Glen Van Roekel**, LeMars, has been named chairman of the Floyd Valley Hospital board of trustees. Dr. Van Roekel has served previously as treasurer. . . . **Dr. Russell Watt**, Marshalltown, spoke on retinopathy at recent meeting of American Diabetes Association, Central Iowa Unit.

Dr. Harold L. Ganzhorn, Mapleton, **Dr. Carlyle Moore**, Emmetsburg, and **Dr. George Hogenson**, Eagle Grove, received "Team Doctor Awards" at recent State Wrestling Tournament in Des Moines. The presentations were made by Iowa High School Athletic Association. . . . **Dr. Jeffrey B. Crandall**, an internist, joined Medical Associates in Cedar Falls on April 1. Dr. Crandall received the M.D. degree at Boston University School of Medicine, Boston, Mass.; interned at Mary Imogene Bassett Hospital in Cooperstown, New York; and had his residency at Cooperstown Hospital and Strong Memorial Hospital in Rochester, New York. Dr.

Crandall has served in the U. S. Public Health Service and also on staff at George Washington University Medical Center in Washington, D. C. . . . **Dr. Robert J. Lynn** retired from medical practice in Eldora on March 1 and moved to Tucson, Arizona in mid-March. Prior to practicing in Eldora, Dr. Lynn was located in New Hampton. . . . **Dr. M. C. Napuli**, Marshalltown, was guest speaker at recent meeting of the Marshalltown Licensed Practical Nurses Association. Dr. Napuli spoke on "Upper Respiratory Infections That Go Into the Inner Ear." . . . **Dr. Marvin Ohsann** recently began a family practice in Davenport. Dr. Ohsann received the M.D. degree at Michigan State University College of Medicine; served his internship and first year of family practice residency at U. of I. College of Medicine and his last two years of FP residency at Mercy-St. Luke's Hospital in Davenport.

Dr. V. H. Carstensen, Waverly, spoke recently to the community's Junior Federated Women's Club. Dr. Carstensen's topic was "Acupuncture." . . . **Dr. R. Bruce Trimble**, Mason City, participated in a recent arthritis workshop in Emmetsburg. . . . **Dr. Mary Gammon**, Spencer, was featured recently in a "Parade" magazine article entitled, "Women Doctors Are Entering All Specialties." The article discussed the small number of women in the United States who are urologists. . . . **Dr. James E. Mansour** will join the Creston Medical Clinic in July. Dr. Mansour is presently chief resident for the family practice residency program at St. Vincent's Medical Center in Jacksonville, Florida. Dr. Mansour received the M.D. degree at University of Missouri Medical School. . . . **Dr. Barry M. Sherman**, associate professor, Department of Internal Medicine, U. of I. College of Medicine, was guest speaker at recent meeting of the Woodbury Medical Society. Dr. Sherman dis-

(Please turn to page 183)

ABOUT IOWA PHYSICIANS

(Continued from page 182)

cussed "Thyroid Function, Disease and Treatment." . . . **Dr. James Shehan**, Red Oak, spoke at recent meeting of Red Oak Kiwanis Club. His topics were medical insurance and physical fitness.

Dr. Craig D. Ellyson, Waterloo, recently discussed the delivery of medical care in Iowa on WOI Radio. Dr. Ellyson is chairman of the IMS Health Education Committee. He has served since 1972 on the Joint American Medical Association and National Educational Association Committee on Health Education. . . . **Dr. Charles F. Schafer**, surgeon, joined the Pella Medical Center on May 1. Dr. Schafer received the M.D. degree at University of Kansas Medical School; interned at Butterworth Hospital in Grand Rapids, Michigan; and served a surgical residency at Queens Hospital in New York City. Prior to locating in Pella, Dr. Schafer practiced in Winona, Minnesota. . . . **Dr. Morely Somersall** began the family practice of medicine in Dumont in March. Dr. Somersall, a native of the Virgin Islands, graduated from Howard University in Washington, D.C., and interned in West Virginia and New York. . . . During the Iowa High School boys basketball tournament in Des Moines, four Iowa physicians were presented team doctor awards—**Dr. Frank R. Richmond, Sr.**, and **Dr. Frank R. Richmond, Jr.**, Fort Madison; **Dr. C. R. Wilson**, Manson and **Dr. G. J. Sutton**, Boone. The presentations were made by the Iowa High School Athletic Association. . . . **Dr. Robert A. Sedlacek**, Cedar Rapids, has been elected chairman of the Cedar Rapids Hospital Council for 1977. Dr. Sedlacek is immediate past president of the Iowa Clinical Society of Internal Medicine.

Dr. Jose Kua, Avoca, attended the American College of Surgeons Convention in Los Angeles, California. . . . **Dr. Ann Bonhaus** recently entered the practice of radiology at Keokuk Area Hospital. Dr. Bonhaus received the M.D. degree at University of Texas Medical School in Galveston, Texas. She served a two-year fellowship in general surgery at the Mayo Clinic and completed her residency in radiology at Veterans Administration Hospital in Dallas, Texas and Roose-

velt Hospital in New York City. . . . **Dr. H. A. VanHofwegen**, Spencer, discussed the programs of the Iowa Heart Association at a recent seminar for area nurses. The event was co-sponsored by the Iowa Lakes Community College and the Clay County unit of the Iowa Heart Association. . . . **Dr. James Dunlevy**, Fairfield, was guest speaker at recent meeting of the Fairfield Women's Club. Dr. Dunlevy's subject, "Cancer." . . . **Dr. Lloyd J. Filer, Jr.**, U. of I. professor of pediatrics, was chairman of a panel for a closed-circuit television symposium, "Infant Nutrition: A Foundation for Lasting Health?" The symposium will be broadcast to 23 major cities in the U.S. and Canada. . . . **Dr. John Mayer** and **Dr. Sue Urbatsch** will join the West Union Medical Clinic staff this summer. Dr. Mayer received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Ramsey General Hospital in St. Paul, Minnesota. Dr. Urbatsch received the M.D. degree at Northwestern University School of Medicine in Evanston, Illinois and completed her family practice residency at Broadlawns Hospital in Des Moines.

(Please turn to page 186)

BE THE DOCTOR YOU WANT TO BE.

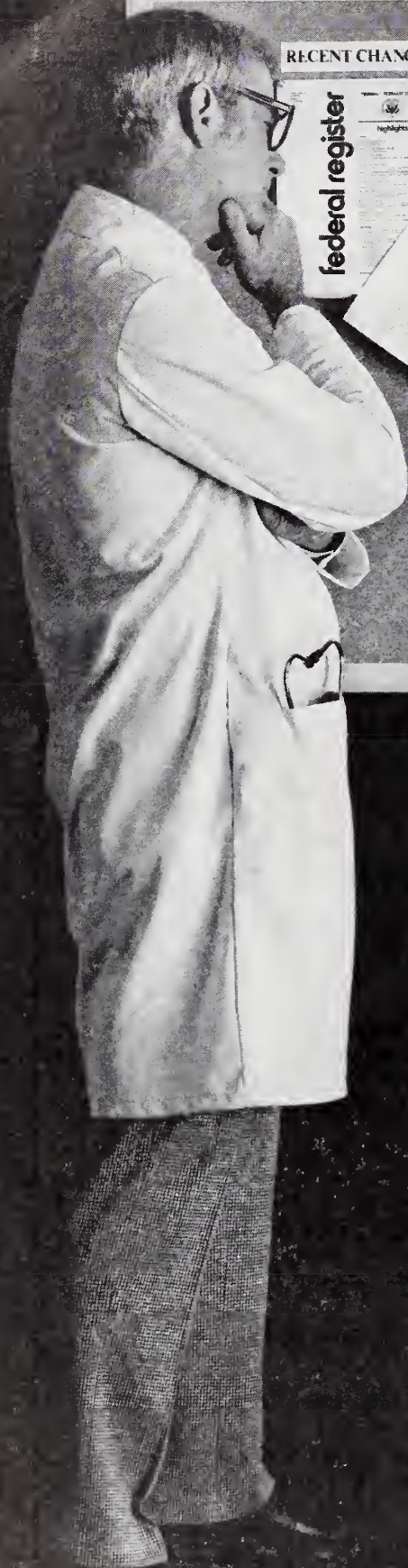
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RECENT CHANGES

federal register

HIGHLIGHTS

Providing Drug Information to Physicians

Informational Bulletin #433-76

National Health Insurance

special report Malpractice insurance:

drug bulletin

Health care doesn't need more red tape

Drug firms challenge 'MAC' rules

Drug Substitution

The American Demonstration of Health Progress
RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Dr. Francis L. Pisney, Red Oak, was guest speaker at recent meeting of Red Oak Rotary Club. Dr. Pisney spoke on future preventive medicine programs. . . . **Dr. Ankiheedu Kavuru** recently opened a cardiology practice in Waterloo. A native of India, Dr. Kavuru is a former consultant cardiologist in the coronary care unit at Metropolitan Hospital in Detroit, Michigan. He attended medical school in India and was an assistant professor of internal medicine at Gunter Medical College in Gunter, India, prior to coming to the United States. Dr. Kavuru received his training in cardiology in Detroit and is certified by the American Board of Internal Medicine. . . . **Dr. Walter M. Block**, medical director of the Child Evaluation Clinic in Cedar Rapids, was guest speaker at recent meeting of Parent Teacher Association in Webster City. His topic "TV Violence and Our Children." . . . **Dr. Clarence H. Denser, Jr.**, Des Moines, president of the Iowa Division of the American Cancer Society, participated with Governor Robert D. Ray in the issuance of an official proclamation designating April as "Cancer Control Month." . . . **Dr. George D. Penick**, professor and head of pathology at U. of I. College of Medicine, has been cited for distinguished service by the University of North Carolina School of Medicine. Dr. Penick taught at UNC from 1949 until 1970 when he joined the U. of I. faculty.

The Dexter Clinic Hospital, which has been owned and operated by **Drs. Keith Chapler** and **C. Robert Osborn**, longtime Dexter physicians, closed May 1. The 17-bed hospital had been in operation since 1926. . . . **Dr. Lawrence Donovan**, Estherville, was guest speaker at recent meeting of Estherville Newcomers Club. Dr. Donovan presented two films entitled, "Women and Cancer" and "Self Breast Examination." . . . **Drs. Donald Doty** and **J. L. Ehrenhaft**, professors in Department of Surgery at U. of I. College of Medicine, participated in recent program sponsored by the Iowa Heart Association and the Section on Cardiovascular Medicine and Surgery at Mercy Hospital in Des Moines. The scientific presentation was entitled, "Spectacular Advances in Cardiac Surgery." . . . **Dr. Robert C. Haakenson** began a family practice in Forest City in April. Dr. Haakenson received the M.D. degree at Louisiana State University. For the last four years he has lived in

Ethiopia, Africa, where he was a missionary doctor for the American Lutheran Church. . . . **Dr. John M. Hennessey**, Manilla, was guest speaker at Crawford County Cancer Crusade Kick-off. Dr. Hennessey is professional service chairman of the Crawford County Unit.

Dr. Clark Cobble, an ophthalmologist, has joined the Bluff Medical Clinic in Clinton. Dr. Cobble received the M.D. degree at Vanderbilt University in Nashville, Tennessee, and completed his internship and residency at Indiana University Hospital in Indianapolis, Indiana. . . . **Dr. Joseph L. Skibba**, Iowa City, was guest speaker at the Washington County Cancer Crusade Kick-off. Dr. Skibba is a clinical fellow in Department of Surgery at University Hospitals. . . . **Dr. Tom D. Throckmorton**, Des Moines, received the Peter Barr Memorial Cup from the Royal Horticulture Society of London, England, at the recent convention of American Daffodil Society in San Francisco, California. Dr. Throckmorton has received worldwide acclaim for his use of the computer in tracing family trees of all known varieties of this flower and in developing new daffodil seedlings.

DEATHS

Dr. Benjamin F. Kilgore, 77, Des Moines, died March 23 at his home. A lifelong Des Moines resident, Dr. Kilgore was a retired eye, ear, nose and throat physician. He received the M.D. degree at the University of Illinois School of Medicine, studied at the University of Vienna, Austria, and was a resident student at the Swedish Mission Ophthalmic Hospital at Tirrappatur, India. Dr. Kilgore served on the staffs of Mercy and Broadlawns Polk County hospitals and on the Des Moines Health Center Board. He was a member of the Iowa Academy of Ophthalmology and Otolaryngology and life member of the Iowa Medical Society.

Dr. F. H. Fillenwarth, 87, longtime Charles City physician, died April 1 at the Americana Nursing Home in Mason City. Dr. Fillenwarth received the M.D. degree at U. of I. College of Medicine in 1915. He was a 50-year member of the Charles City Lions Club and life member of the Iowa Medical Society.

Medical Assistants



by BETTY EHLERT, CMA-A

PRESIDENT'S MESSAGE

Margaret Porter, CMA-AC, was installed as president of the Iowa Chapter, American Association of Medical Assistants, at the state con-

vention in April. Margaret has been employed as medical secretary by Donald D. Weir, M.D., in the St. Luke's Methodist Hospital Rehabilitation Center in Cedar Rapids. She has served two years as state vice-president and has held various local chapter offices. Her inaugural message follows.

INAUGURATION REMARKS

The year 1976 was an exciting year: Celebrating the 200th anniversary of America and the 20th anniversary of AAMA. America has come a long way in 200 years, from 13 colonies to the leading nation of the world. So too, AAMA has grown to be a nationally recognized organization of practicing medical assistants.

The year 1977 is upon us, and we, AAMA, are continuing to grow—in quantity and quality. Quantity has come from increased interest of persons wanting to work together as an organization to provide better health care to the physician's patients. Quality has come through continuing education. It is through reviewing and improving our skills that we are able to keep abreast of the changes taking place in the profession of medicine. Our physicians attend numerous local, state, and national

meetings, conventions, workshops, etc., to keep up with changes in their particular fields of medicine. If they are to keep up with the changes, they can expect their office staffs to do the same.

For the medical assistant to keep up with the changes taking place nearly daily, she too must have continuing education. AAMA provides this opportunity on the local, state, and national levels. Local monthly meetings help the medical assistant be informed of the changes and new developments in the community. District seminars, state and national conventions allow her to expand into areas not readily available on the local level. Modern medicine places considerable responsibility on our physicians to provide good health care. This also means good allied health care through competent, qualified, informed office personnel. AAMA helps the medical assistant in this never ending challenge to bear the pressures and enjoy the pleasures of her daily responsibilities.

"You must always be students, learning and unlearning till your life's end, and if you are not prepared to follow your profession in this spirit, I implore you to leave its ranks and betake yourself to some third-class trade." (Lord Lister Joseph)

MARGARET PORTER, CMA-AC, President



MARGARET PORTER

CLASSIFIED ADVERTISING RATE—\$1 per line, \$10 minimum per insertion. NO CHARGE TO MEMBERS OF IOWA MEDICAL SOCIETY. Copy deadline—10th of the month preceding publication.

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OB-GYN, PEDIATRIC SPECIALISTS needed by 16-man multi-specialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., LaCrosse Clinic, 212 South 11th Street, LaCrosse, Wisconsin 54601.

PHYSICIAN WANTED—Student Health Service Physician. Excellent University with attractive campus and performing arts center. Excellent fringe benefits. Salary negotiable. Contact L. Z. Furman, M.D., Student Health Service, Iowa State University, Ames, Iowa 50011. 515/294-5801.

FOR SALE—Well established dermatological practice for reasonable price of equipment. Sickness reason for retirement. Contact Herbert C. Leiter, M.D., 531 Badgerow Building, Sioux City, Iowa 51101. 712/255-3585.

ORTHOPEDIC SURGEON, OPHTHALMOLOGIST, OBSTETRICIAN-GYNECOLOGIST, and CARDIOLOGIST wanted to join established 20-man multi-specialty group in north central Iowa. Immediate full financial partnership and outstanding benefits. New clinic building and hospital. Progressive community with excellent schools and recreational facilities. Address your inquiry to No. 1523, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

WANTED PHYSICIANS—ALL SPECIALTIES—As search consultants in the health care field, we are interested in physicians with a good career path for full-time positions as Medical Director, Assistant Medical Director, Chiefs of Clinical Departments, and clinical practice with our clients, blue-ribbon hospitals and other organizations in the health care field. We invite your curriculum vitae so that we may contact you when the right situation develops. No financial obligation to candidate. Contact LEPINOT ASSOCIATES INC., 702 ABBOTT ROAD, EAST LANSING, MICHIGAN 48823.

FOR SALE—Used extra examining room furniture and equipment, also, business machines and office furniture. Call 515/858-3612.

FAMILY PRACTITIONER WANTED—To join 6-man group; newest city in Iowa; new hospital; well established group; production contract, short time to full partnership. Contact Ed Murphy, Carroll Medical Center, 502 N. Court, Carroll, Iowa 51401.

CEDAR RAPIDS, IOWA, SEEKS EMERGENCY PHYSICIAN—Full time. Join five others. Salary to start then full partnership if compatible. Start July 1, 1977. Approximately 30-40 hour week. Unique opportunity. For further information contact W. E. Kettelkamp, M.D., St. Luke's Methodist Hospital, 1026 A Avenue, N.E., Cedar Rapids, Iowa 52402. Phone 319/398-7211.

EMERGENCY ROOM PHYSICIAN WANTED—Keokuk, Iowa starting April. Percentage fee-for-service with guaranteed minimum of \$50,000 per year for two days work per week. Write No. 1525, Journal of the Iowa Medical Society, 1001 Grand

LIST YOUR WANTS

Avenue, West Des Moines, Iowa 50265, or call direct 415/435-0689.

FAMILY PHYSICIAN WANTED—Young group of four doctors, three fully active, desire young associate in Winterset, Iowa. Newly remodeled and expanded office. JCAH approved hospital. Good proximity to Des Moines (35 miles) for referrals, etc. Expanding practice with plenty to do. Competitive salary. No purchase of partnership needed after first year. Contact Nelson H. Chesney, M.D., 115 West Court, Winterset, Iowa 50273. Phone 515/462-1040.

PSYCHIATRIC RESIDENCY—Vacancies for positions for July 1, 1977, for those who have a regular Iowa license or can obtain one by reciprocity or via the FLEX. Prepare for career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, Children's Unit, Adolescent Unit. Neurology Affiliation with University of Iowa. The stipends are: 1st year, \$21,294; 2nd year, \$22,360; 3rd year, \$23,478. Intensity and diversity of training program appreciated best by personal visit. T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012. Equal Opportunity Employer. Call Collect 712/225-2594.

EMERGENCY MEDICINE—physician wanted for major suburban hospital. One of five full-time M.D.'s. New department. Hospital based specialists in neonatology, pulmonary disease, pathology, cardiology, radiology and anesthesia. Full partnership after two years. Tax-sheltered annuity available and retirement provided. Existing four M.D.'s average age is 34. Joseph R. McCaslin, M.D., Director of Emergency Medicine, Archbishop Bergan Mercy Hospital, Omaha, Nebraska 68124. 402/398-6031.

RADIOLOGIST AVAILABLE as locum tenens for July, August and September. Write AIR MAIL to—G. Bruno, M.D., via Nazionale 196/4, 34016 Opicima, Ts., ITALY.

FOR SALE—Every office reception room should have a copy of "Unseen Battles of the Night" by S. W. Barnett, M.D., Cedar Falls, Iowa. Send check for \$7.50 to Box 485, Cedar Falls, Iowa 50613 and a copy will be sent postpaid.

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President's Page

A new work-year is starting. One year ago Dr. Jim Bishop eloquently stated how important it is that our Society "grow in service, size and strength." We are all grateful to him for his year as President, and the stewardship toward these ends. Much has been accomplished.

Today professionalism is under more scrutiny than ever before—some call it attack. The words *accountability* and *responsibility* have taken on a new meaning which we must all be aware of and meet their challenges. It is satisfying to note that the medical profession rates very high in public confidence, as indicated in recent Gallup Polls. But we must continue to deserve it to maintain that status.

To do so, we and our very capable Society staff must monitor and participate in almost myriad health related activities, including proposed legislation, and, yes, bureaucratic fiat, to influence all this in the right way as much as we can. The "right way" is what we believe to be better and better medical care for our patients, the public. Cost-consciousness must enter that picture.

With the increased resources just approved by the 1977 House of Delegates for next year, you may be sure the officers and staff will try again to carry out Jim Bishop's ideals for the Society.

My personal credo has always been to try my best to practice the kind of medicine I would like were I the patient. I promise you I'll work to keep this possible.

Don't forget Jim Bishop's very fine scientific session this July. Continuing medical education is in the public and legislative spotlight. It is nice to have CME recognized as important inasmuch as we have always espoused it for ourselves in order to be knowledgeable, good doctors.

The close working relationship with the U. of I. College of Medicine and its training and educational programs is most important in this effort. I am sure this cooperation will continue to the advantage of all patients and physicians in the state.



L. W. Swanson M.D.

L. W. Swanson, M.D., President

IOWA Medical Miscellany

NEW OFFICERS . . . 1977-78 IMS President L. W. Swanson, M.D., Mason City, accepted his gavel of office May 7 from predecessor J. F. Bishop, M.D., Davenport. Other officers either elected or re-elected by the 1977 House of Delegates were R. S. Gerard, M.D., Waterloo, president-elect; R. T. Melgaard, M.D., Dubuque, vice-president; L. D. Caraway, M.D., Amana, speaker of the House; J. H. Lohnes, M.D., Cedar Rapids, vice-speaker; J. H. Kelley, M.D., Des Moines, trustee; J. R. Anderson, M.D., Boone, AMA delegate; and E. B. Mathiasen, M.D., AMA alternate delegate. Blue Shield liaison delegates chosen were C. W. Seibert, M.D., Waterloo, and J. D. Ver Steeg, M.D., Des Moines.

BOARD CHAIRMAN . . . J. H. Kelley, M.D., Des Moines, has been chosen by the IMS Board of Trustees as its 1977-78 chairman.

HOUSE ACTIONS . . . As reported in a May IMS UPDATE, the 1977 House of Delegates (1) opposed broadening the optometric practice act to allow for the use of diagnostic or therapeutic drugs; (2) rejected the idea of making patients' records the property of the patient; (3) objected to including the offices and services of a private physician or clinic in any "certificate of need" legislation; (4) opposed a change in Iowa law to permit hospital employment of physicians for the purpose of selling their services to the public, and (5) resisted giving statutory authority to physician's assistants to write prescriptions.

PHYSICIAN'S ASSISTANTS . . . The 1977 House of Delegates reaffirmed Society support for the Iowa law which governs PA's and supported the Board of Medical Examiners in its administration of the law. Further evaluation of physician extenders was urged by the House with the suggestion the IMS maintain liaison with the AMA, BME and College of Medicine as further developments occur in this area.

JUDICIAL COUNCIL . . . The 1977 House ratified the district nomination of the following IMS councilors: W. V. Wulfekuhler, M.D., Mason City (II); D. J. Walter, M.D., Des Moines (V); J. E. Tyrrell, M.D., Manchester (VII); R. L. Kent, M.D., Burlington (VIII); S. A. Smith, M.D., Oskaloosa (IX), and E. E. Linder, M.D., Ogden (XII). Drs. Tyrrell and Youngblade were re-elected chairman and secretary, respectively.

TOP AWARDS . . . K. E. Lister, M.D., Ottumwa, received the 1977 IMS Merit Award May 6 at the Delegates' banquet. Dr. Lister is a past president and past IMS board chairman and was the first president of the Iowa Foundation for Medical Care. L. T. January, M.D., professor of internal medicine at the U. of I. College of Medicine, was awarded the Ben T. Whitaker Teaching Award of the Interstate Postgraduate Medical Association of North America.

'78 DUES CHANGE . . . Strong support was given by the 1977 House of Delegates to a recommended dues increase, the first such authorization since 1973. A \$75 increase will become effective in 1978, bringing the dues level to \$275. A financial report was mailed to all IMS members prior to the May House session which contained reference to the recommendation.

OTHER ACTIONS . . . IMS members were urged by the House to be aware of the factors involved in the cost of health care. Also, the House directed that a study be made of the adolescent pregnancy problem in Iowa. Additionally, the House turned down a proposal for "unified membership" and asked the Board to explore increased administrative staff assistance for county medical societies.

COMMITTEE APPOINTMENTS . . . Appointees to 1977-78 IMS committees will be advised of their selection in a June mailing.

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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Iowa Workers' Compensation In Summary

ALAN R. GARDNER, J.D.

Des Moines

Medical opinion represents an important aspect of the Iowa Workers' Compensation Program. This summary is provided to help Iowa physicians better understand the nature of the program and their role in its administration.

WHAT do you want from my report? This question is asked frequently by Iowa physicians who become frustrated when requested by attorneys and insurance company representatives to provide medical reports in Workers' Compensation cases.

It is fair to say many physicians do not fully understand what data is relevant in Workers' Compensation cases. It is also fair to say many lawyers and insurance personnel do not present their requests for information understandably.

There is a substantial involvement by the medical profession in Iowa Workers' Compensation. This makes it important for physicians to have a basic understanding of the program which affords benefits to injured employees. It is hoped this discussion will help the Iowa physician better recognize why his opinions and comments are needed—as well as the manner in which they will best serve the parties involved.

As elsewhere, the Iowa Workers' Compensation program is a creation of the state legislature. It provides benefits to the employee who sustains a work-connected injury. The fault of the employer or employee is irrelevant. The employer must insure his liability with a Workers' Compensation carrier or qualify as a self-insured.

It is generally understood that payment of medical bills and other benefits under the Iowa Work-

ers' Compensation Law comes from the insurance carrier or one of the few self-insured employers. To determine what are the proper and required payments, the insurance carrier must investigate a claim to decide its merits and magnitude. The medical condition of the injured employee/claimant is an important part of this investigation.

The need for prompt claim-handling is apparent. The insurance carrier is expected to secure the necessary information expeditiously. In the process, the company must decide if the injured employee is entitled to receive benefits and the nature of the benefits. If no dispute emerges as to the nature and extent of the injury, benefits are paid voluntarily. If a dispute does arise over the injured employee's right to benefits, then litigation may be commenced before the Iowa Industrial Commissioner. When this need arises the attorneys for either the injured employee or the employer become the requestors of information.

Recent changes have been made in Iowa law which pertain to the admission of evidence in administrative hearings. As a consequence, medical reports are now used frequently in Workers' Compensation hearings in lieu of testimony or depositions. This gives the contents of the medical report greater significance than before. Previously, questions and points not noted in the report might be covered during testimony.

The Iowa Supreme Court has ruled where complex medical matters exist expert medical opinion is necessary to establish an injured employee's right to benefits. Without medical opinion an injured employee may be unable to receive benefits or payment of expenses.

PURPOSE OF MEDICAL REPORT

In the first instance, medical opinion is needed to relate the injury to employment. Iowa recognizes that a work injury or the work environment may be the initial causative factors or they may be aggravating factors when a prior condition exists. In this context, aggravation means a significant subsequent episode which bears on an existing condition and results in further problems.

Mr. Gardner is Deputy Industrial Commissioner for the State of Iowa. His summary discussion received its impetus from liaison between the Iowa Medical Society Committee on Industrial Medicine and the Industrial Commissioner's Office.

Aggravation is not ordinarily considered to be present in a work-connected injury when it takes the form of an underlying discomfort upon activity. However, when a future disability appears work-precipitated, even without the presence of a specific injury, it may be compensable. Both mental and physical results of an injury can be compensated.

Medical expertise is needed to establish fully that a causal relationship exists between the injury and the employment setting. This can be illustrated by exposure to an allegedly toxic substance. When such a claim is made the medical expert is needed to explain (1) if the substance is toxic, and (2) if the circumstances which are claimed resulted from the exposure.

The cause and effect relationship between the work and the injury must be within the realm of probability. If only a possibility of a relationship exists, then the injury is not compensable under the Workers' Compensation Law. In his report, a physician may express the opinion, "Yes, the condition I found could have been brought about by the patient's employment incident." In and of itself this is insufficient to establish the claim. However, other factors may exist which when combined may permit the injury to be found compensable. These additional factors include the absence of any other possible cause and the proximity of time between the work incident and the onset of difficulties.

Once compensability is no longer an issue, an injured employee is entitled to various types of benefits under the Iowa Workers' Compensation Law. All medical expenses necessary and incident to the injury are to be paid. In addition, Iowa law provides for weekly benefits. These include temporary total disability, healing period, permanent partial disability and permanent total disability benefits. In addition, benefits are payable to the dependents when a work-connected death occurs.

Temporary total disability is paid to an injured employee when he cannot perform any gainful work due to the injury. It is payable when no permanent bodily impairment is expected.

Healing period benefits are payable until a claimant returns to work or has recuperated from the injury. Recuperation occurs when it is medically indicated that either no further improvement is anticipated from the injury or that the employee is capable of returning to employment substantially similar to that in which he was engaged at the time of the injury, whichever comes first.

Permanent partial disability has two facets. One applies to the so-called "scheduled member" injuries. The other relates to injuries resulting in "industrial disability." The former is represented by injuries to a specific body extremity, such as arm, leg, finger, eye, etc. When a scheduled member is involved the only relevant inquiry is the percent of impairment to the body member. The percent is applied to the weekly statutory value, i.e., an arm equals 250 weeks, a leg equals 220 weeks. Thus a 50% impairment of an arm provides the injured employee 125 weeks of permanent partial disability compensation. The effect on the injured employee's ability to earn wages is irrelevant. When "non-scheduled" injuries occur, i.e., back, head, multiple members, etc., inquiry is made as to the effect of the injury on the employee's ability to earn wages. The bodily impairment is one of many factors used to determine the industrial disability.

The most important information to be ascertained from a physician is the bodily impairment rating. Quite often a physician will express an opinion as to a man's industrial capacity. But these opinions are of limited value unless they relate the bodily impairment to those functions which are required of the injured employee as described in his work history. It is helpful when the physician provides an explanation to support his opinion regarding the work capabilities of an injured employee; this is particularly true when the opinion goes beyond functional or bodily impairment. The appropriate percent of permanent partial industrial disability is applied to a 500-week framework. Thus, a 20% permanent partial disability rating results in a claimant receiving 100 weeks of disability compensation.

A permanent total disability refers to the individual who is, for all practical purposes, removed from any gainful employment by injury. As in permanent partial disability, the bodily impairment is only one factor to be weighed in making the determination. An injured employee will receive weekly benefits for life if totally disabled.

Determining the rights and benefits of an injured employee requires investigation. It may proceed to litigation. In the process, the prompt opinion of a physician is valuable and becomes an important part of the decision-making process. Each of the facets described in this discussion is present to some extent in nearly every case. If the reports of physicians are written with the noted elements in mind, benefits will accrue to all parties involved.

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Educationally Speaking

by R. M. CAPLAN, M.D.

THE INEFFICIENCY OF EDUCATION

At meetings I attend where “educators” hold forth, I often hear critics lament that continuing education has not been *proven* to make a favorable difference in the process or outcome of medical care. That notation always squeezes my adrenals for a variety of technical and emotional reasons that I won’t take space to list just now—except for one.

The criticism implies (to me) that continuing education, or any education for that matter, is intrinsically efficient and that effort given to it will or should pay off in large measure. I wonder where such an idea comes from. The learning of intellectual information, the mastery of technical know-how, the ability to formulate abstractions in behalf of evaluation or problem-solving—all these are widely recognized to require lots of rehearsal and repetition, whether it be the multiplication tables in third grade, the catechism in Sunday School, the strategy for winning at poker, or the criteria to diagnose diseases. Because of the ample time needed for facts, concepts and skills to be adequately integrated, most medical schools that recently compressed their curriculum into three years have now returned to the four-year program. Why then does there arise this curious expectation that increments of learning will be quickly absorbed and put into action simply because the learner has now become a practicing physician?

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

The theory of calculus involves slices of area so thin as to have essentially zero width, yet all the slices can be “integrated” or summed into substantial areas. Similarly, it seems to me, we need to regard CME experiences as small units often of very little substance when measured individually (or even too small for our crude measuring tools), yet capable of being summed in the operational world of the learner.

One of the giants of experimental psychology and learning at the turn of this century was Ebbinghaus, whose studies gave rise to his “curve of forgetting.” Everything we learn tends to decay with great rapidity, although repetition or use of the knowledge can greatly improve retention. The critics mentioned above seem to have forgotten what they learned about Ebbinghaus and his work, which simply shows again how correct he was.

A well-stated version of this problem was offered by K. Patricia Cross, of the Educational Testing Service, who said recently:

“The human mind is a marvelous thing, but we abuse it when we assume that storage and retrieval of information is its greatest asset.

“The forgetting curve starts with 60 per cent retention immediately following a lecture, dropping to about 20 per cent after eight weeks.

“In our rapidly changing world, there is no permanent body of knowledge that can be passed along to youth in the hopes it will last a lifetime. There are only intellectual skills and attitudes and appreciations about learning that will help people use their minds throughout their lifetimes.

“And active, inquiring minds are as likely to be found among 50-year-olds as among 10-year-olds.”



SCIENTIFIC ARTICLES

Massive Hemorrhage Following Tracheostomy

JAMES M. CATERINE, M.D.

Des Moines

MASSIVE HEMORRHAGE of a tracheal-arterial fistula is among the most catastrophic of post-operative complications. Usually the patient exsanguinates into his airway bringing death in seconds. Ideally, this event should happen only when a thoracic surgeon is at the bedside (1) with necessary equipment, and (2) with an anesthesiologist and operating room staff immediately available. If it should occur only when hospital nursing personnel are present, the patient's chances for survival are nearly zero. Under these circumstances, the patient's fate depends entirely on the ability of nursing personnel, or possibly a house officer, to recognize the complication and take appropriate and expeditious resuscitative measures.

CASE REPORTS

Case 1: D. L., an 8-year-old male was admitted to Mercy Hospital, Des Moines, Iowa, January 6, 1976, for head injuries resulting from an automobile accident. An endotracheal tube was inserted on his arrival in the Emergency Department to assist respiration and control secretions. An uneventful tracheostomy was performed about 7

This paper was presented at the 1977 meeting of Iowa Academy of Surgeons in Dubuque, Iowa, on April 22-23.

The author is in the private practice of surgery in Des Moines, Iowa.

Massive hemorrhage from a tracheal-arterial fistula is a spectacular and devastating complication. Two case reports are presented here. Quick and appropriate action is crucial if the patient is to be maintained.

days later. The tracheal opening was made in the ring just below the cricoid cartilage. A metal tube was used due to the unavailability of the proper sized synthetic cuffed tube (Shiley). On the fourteenth day post-tracheostomy, the patient suddenly began bleeding massively from the tracheostomy tube. Attempts by the house officer and intensive care unit nurses to apply pressure were unsuccessful and the patient expired within minutes. No physicians were available to assist in the attempted resuscitation. The patient was decerebrate. Autopsy was not granted. This is a case of suspected and probable tracheal-innominate fistula.

Case 2: J. O., a 13-year-old male sustained a head injury in a mini-bike accident, August 28, 1974. He was admitted to the Emergency Department at Mercy Hospital, Des Moines, Iowa. A delayed tracheostomy was performed on the eighth hospital day for ventilatory assistance and tracheal toilet. He was decerebrate. On the fifteenth day after the tracheostomy, massive bleeding occurred from the tracheostomy tube. A pediatrician and a thoracic surgeon were immediately present and directed resuscitation. Digital pressure and

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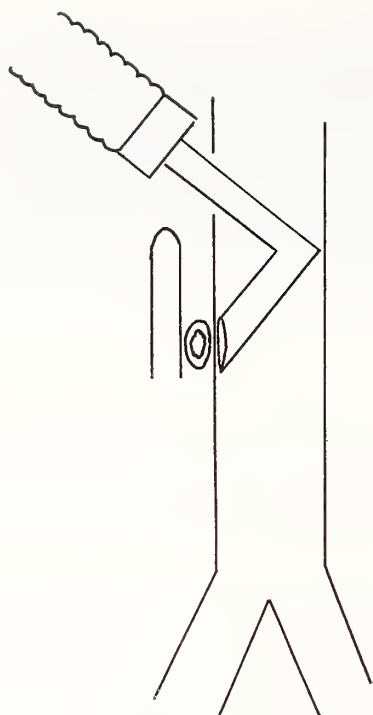


Figure 1

elevation of the cuff of the tracheostomy tube stopped the bleeding. The patient was transported to the operating room immediately where median sternotomy was performed. The opening in the innominate artery was found and closed. Five days later, massive bleeding recurred from the tracheostomy tube, and the patient was returned to the operating room. This time a bypass graft was inserted, resecting the portion of the innominate artery communicating with the trachea. The patient survived this procedure only to begin bleeding massively from the tracheostomy opening six days later. He was dead in a matter of minutes. Autopsy was not granted. This is a proven case of massive hemorrhage from a tracheal-innominate fistula. This case is the only one in the literature to survive not one but two operative procedures.

DISCUSSION

Tracheal-arterial fistula is relatively rare, representing 1% of post-tracheostomy complications.^{6, 13} Major vessel hemorrhage was not reported in two large series of tracheostomy complications reviewed by Oliver *et al*² and Meade.¹⁶ It usually occurs in the first three post-operative weeks following tracheostomy.⁶ However, it may occur anywhere from several days to months after a tracheostomy is performed.^{8, 13, 15} Statistically, the event is unlikely to occur more than once in

any private surgical practice. When it happens there is no time to "look it up" or call a consultant. Time is of the essence. It behooves every physician to be aware of the complication and to have a plan of management in mind. Furthermore, all nursing personnel who care for tracheostomy patients should have in-service training on the diagnosis and treatment of this complication.

Two clinical signs of impending massive hemorrhage from a tracheal-innominate fistula have been reported. Biller and Ebert¹² indicate that 50% of the time the first hemorrhage will be massive, and the remaining 50% will experience minor bleeding episodes prior to the massive hemorrhage. Usually, late minor hemorrhage is due to tracheitis or stoma irritation,^{6, 12} but when this occurs, imminent innominate artery erosion should be suspected. Another sign considered pathognomonic of impending innominate artery erosion and hemorrhage is a pulsating tracheostomy tube.^{5, 6, 11} Either one or both or neither of these signs may be present. Minor bleeding episodes preceded the massive hemorrhage in Case 1 but not in Case 2. Tracheostomy tube pulsation did not occur in either.

Normally, the innominate artery passes obliquely in a left to right direction in front of the trachea and behind the sternum. The erosion usually occurs in the superior-medial wall of the artery at a point between its origin from the aortic arch and its bifurcation into the right subclavian and right common carotid arteries. This anatomic relationship suggests that major hemorrhage from a tracheostomy is related to the tracheostomy tube position with the vessel involved. In 75% of the cases the trachea communicates with the innominate artery while the remaining vessels involved are the carotid artery, the superior thyroid artery, the inferior thyroid artery, the right innominate vein and the aortic arch.^{8, 15}

Some authors report the tip of the tracheostomy tube (with elevated cuff) is the point of pressure on the artery.^{5, 13} It is possible the angulation of the tracheostomy tube, along with the drag of the ventilator tubing on the tracheostomy tube, forces the convex side of the tube to the posterior wall of the trachea. This may cause the tip of the tracheostomy tube to fix on the anterior tracheal wall and exert pressure on the wall of the innominate artery.^{8, 13} This is illustrated by Figure 1. Other authors report this mechanism is uncommon. Some state it is the concave (underside) portion of the tracheostomy tube, before it enters the trachea, which is in apposition with the artery

(Figure 2) usually due to a low placement of the tracheal fenestra or, on occasion, an abnormally high innominate artery.^{3, 11, 12, 14} It would appear that either one of these explanations, or perhaps any combination, might be present in any given case. One can visualize the possibility of fistulization when a tracheostomy tube is placed in the second or third tracheal ring with an abnormally high innominate artery or a normally placed artery with a low-placed tracheal opening below the third tracheal ring. It is not unreasonable to consider that long term cuff elevation in patients requiring ventilatory assistance could cause pressure necrosis of the tracheal wall. This would increase the susceptibility of the anterior tracheal wall to further damage by the tip of an improperly fitted tracheostomy tube or one which is under unusual tension by the pulling of ventilator tubes in the decerebrate, restless patient. Eventual fistulization and erosion into an adjacent vessel would not be a surprising sequelae to these events.

Brantigan⁶ believes infection plays a role in the erosion process which has not been stressed adequately in the literature. He cites a case of fatal innominate vein hemorrhage where no tube was present and directly relates this to infection after extubation. Unfortunately, in spite of strict sterile technique, the majority of tracheostomies become infected.

TREATMENT

The course of action to be followed when this devastating event occurs differs somewhat in the literature. The following approaches seem the most logical and represent a review of the literature. It is generally accepted the first action should be to immediately elevate the cuff of the tracheostomy tube. If this does not stop bleeding, it can be assumed the point of erosion is not related to the tip of the tracheostomy tube. Utley *et al*³ recommend that if cuff elevation does not stop the bleeding one should immediately dissect the innominate artery off the anterior tracheal wall with blunt finger dissection and occlude the vessel against the sternum with the dissecting finger (Figure 3). This was done in Case 2. The tracheostomy tube should be removed and replaced with a cuffed endotracheal tube to provide a satisfactory airway and prevent aspiration of blood. The finger pressure must be maintained until the vessel is controlled in the operating room. As an alternative to the finger pressure maneuver, if elevation of the cuff is ineffective, one may try packing gauze into and around the tracheostomy tube pushing the gauze well into

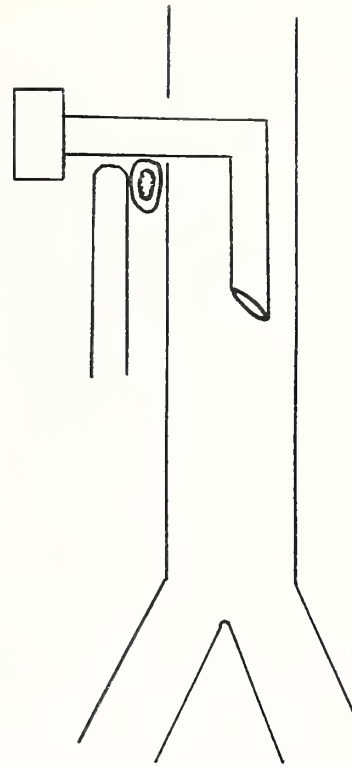


Figure 2

the trachea to create a tamponade. Myers and Pilch⁴ reported success with this approach in one case. They extended the original tracheostomy incision proximally to the inferior border of the thyroid cartilage to accomplish this. The cuff should be kept elevated to prevent flooding of the airway with blood. This approach has the disadvantage of making necessary the surgical extension of the wound. Whichever of these methods is used, as soon as the hemorrhage is controlled, immediate transfusion of crystalloid or colloid should be carried out to maintain blood pressure. The patient should be transferred to the operating room immediately for definitive surgery. Almost every author agrees that median stenotomy should be performed once hemorrhage is controlled. Attempts have been made to dissect out the fistulous tract and repair the artery but because of the friability of the vessel and surrounding tissues, this has proved to be less than effective.^{4, 11} This is also illustrated by Case Report 2. Most reported survivors of this complication had division of the innominate artery with distal and proximal cut ends oversewn.^{8, 12, 13} No neurologic deficit occurred in any of these cases. Use of a replacement graft has not been proven effective, and, in fact, is contraindicated in this contaminated situa-

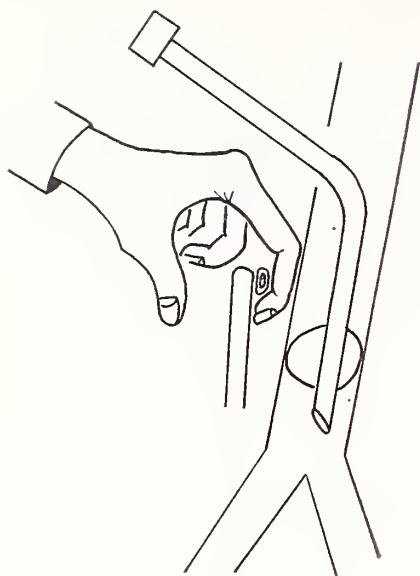


Figure 3

tion.^{3, 8, 12, 13} This approach did not prove to be effective in Case Report 2.

As in most complications, prevention remains the best treatment. It is apparent that extreme care should be taken to place the tracheal opening no lower than the third tracheal ring. This attention to detail when doing the tracheostomy should present no problem since this procedure is usually, and should be, done under strict control in the operating room with the benefit of anesthesia. If assisted ventilation is required, the cuff should be deflated routinely to avoid erosion from constant pressure. Excessive movement and drag created by ventilator tubes should be avoided to prevent tension on the tracheostomy tube. Frequent and routine tracheostomy tube changes should be made. This is especially important if pulsation of the tube has been noticed. Tracheostomy tubes of different lengths and diameters should be used in this situation. Emphasis should be placed on continued aseptic technique in the routine care of tracheostomies. As mentioned earlier, this complication should be the subject of an in-service training program for all nurses and

house officers who manage the tracheostomized patient.

SUMMARY

Massive hemorrhage from a tracheal-arterial fistula is a spectacular and devastating complication. Often times it is heralded by minor bleeding and/or pulsation of the tracheostomy tube. All hospital personnel charged with the care of the tracheostomy patient should be aware of these ominous signs. Further, since massive hemorrhage may occur at times when physicians are not in the hospital, these personnel (nurses, house officers, etc.) should know what course of action is needed if the patient is to be salvaged. If the patient gets to the operating room, median sternotomy with division of the innominate artery is the procedure of choice. Two case reports were presented. One patient died within seconds after the massive hemorrhage occurred from the suspected tracheal-innominate artery fistula. The other survived two massive hemorrhage events and two surgical procedures only to die from recurrent massive hemorrhage the third time.

These two case reports illustrate how the circumstances and time of the hemorrhage may influence the outcome. The first occurred early evening on a weekend night with no attending physician in the hospital to conduct resuscitative efforts; the second occurred during the morning of a routine workday not only with one but two physicians (one a thoracic surgeon) in the immediate area resulting in a successful resuscitation and subsequent surgery. This report is for the purpose of acquainting all physicians with this complication, and includes suggestions regarding the immediate management and surgical procedure of choice for definitive treatment. Key nursing personnel may benefit from this discussion because they may be confronted with this unfortunate complication.

REFERENCES

The references contained in this paper are available on request either from the author or from THE JOURNAL OF THE IOWA MEDICAL SOCIETY.

PROFESSIONAL LIABILITY

As of early May, more than 110 policies had been issued to Iowa Medical Society members entering the IMS/Aetna Liability Insurance Program. This includes physicians transferring from

individual Aetna coverage as well as members totally new to Aetna. Additional applications are in process.

For information on the program, contact IMS Headquarters (515-223-1401) or Aetna (800-362-1809).

Long Term Care in Iowa

ROY W. OVERTON, M.D.,

STEPHEN C. GLEASON, D.O., and

LARRY L. BREEDING

Des Moines

This short review of long term care in Iowa identifies the three levels available. It describes the physician's responsibilities in assisting patients concerned over the proper living conditions.

LONG TERM HEALTH CARE facilities, formerly referred to as nursing homes, are licensed in Iowa under Chapter 135C, CODE OF IOWA. This law was amended in 1975 and consolidated the previous eight levels of care into three, i.e., skilled nursing facility, intermediate care facility, and residential care facility.

Skilled nursing facilities are required to provide services certified by a physician and must be provided under the direction of a registered nurse on a 24-hour per day basis.

In intermediate care facilities, the care is again certified by a physician and is provided under the direction of a registered nurse or licensed practical nurse.

In residential care facilities, no nursing services are provided except on an emergency basis, but the facility does provide "assistance in independent living," primarily for those individuals who do not have serious health problems but have physical infirmities which require minimal assistance in daily living activities.

PAYMENT APPROACHES

Payment to facilities for services rendered is provided under three methods:

Drs. Overton and Gleason are in the private practice of general medicine in Des Moines. Mr. Breeding is executive vice president of the Iowa Health Care Association.

(1) Private pay wherein the individual or the family pays for services provided the resident by the facility.

(2) The Medicare program, which in Iowa is basically limited to skilled nursing facilities.

(3) Title XIX, the Medicaid program, which pays for services delivered in intermediate care facilities to the medically indigent.

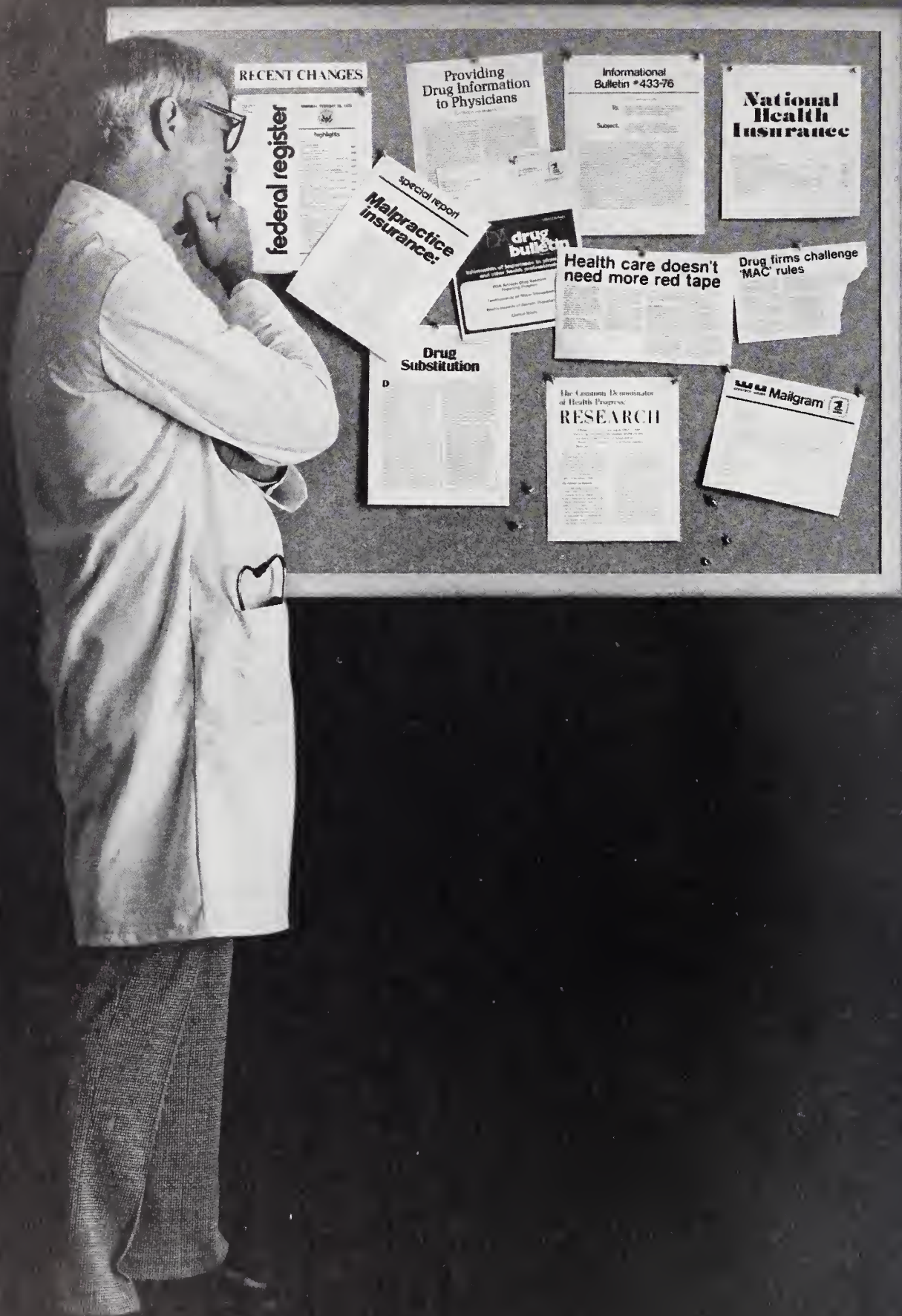
Note: Insurance programs which include long term care benefits are non-existent.

The restructuring of the Iowa law into the three levels of care basically complies with federal guidelines for the Medicare and Medicaid programs. In Iowa, skilled nursing facilities under Medicare have been limited essentially to hospital stays where rehabilitative services are provided as opposed to extended care benefits. In some states, skilled care is provided for extended care under the Medicare program. However, in Iowa the basic program for providing services to the medically indigent for extended care services is the Title XIX Medicaid program, which is geared for the intermediate care facility.

As related to the delivery of long term care services, the physician's responsibility initially is to make the medical determination that a patient is in need of such a level of services as provided by the long term care facility. Once the patient, his family and physician agree that institutional services are necessary, a facility must be selected and determination is then made as to how the services are to be purchased. If the resident and/or his family pay for the services, the responsibility of the physician is the customary patient/physician relationship. While there are licensing requirements which a facility must comply with as to record keeping, essentially there is no further legal requirement as it pertains to the physician's responsibility to the patient.

MEDICAID REQUIREMENTS

However, if the services to be provided are to be paid for by the Title XIX Medicaid program,



RECENT CHANGES

federal register

Providing Drug Information to Physicians

Informational Bulletin #433-76

National Health Insurance

special report
Malpractice insurance:

drug bulletin

Health care doesn't need more red tape

Drug firms challenge 'MAC' rules

Drug Substitution

The Consumer Demonstrator of Health Progress

RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

the physician in addition to certifying initial entry has two other responsibilities: (1) he must recertify on a 60-day basis that the patient is still in need of the services being delivered—in other words, he reconfirms his diagnosis on initial entry; (2) the physician must, on a 90-day basis, review the plan of care of the patient and satisfy himself the services prescribed are being delivered. In addition, facilities may contact physicians for their expertise in selected areas, especially in skilled facilities. This relates mainly to the medical director, but by and large, the relationship is one of patient/physician with the facility being required to provide the services as directed by the physician.

Another possible physician responsibility involves determining if alternatives to institutionalization are available. The broad term, "in-home health care services," has been used to define those services that could be provided on an in-home basis. If the resident, his family and physician determine that in-home health services are available and if the physician is satisfied that the services will be rendered, this, of course, constitutes an alternative to institutionalization. However, the current status of in-home health care is somewhat fragmented and there is not a uniform delivery system. There is inconsistency of delivery here and no uniform method of paying for services delivered the medically indigent.

EXTENSION OF SERVICES

One concept currently being developed is the utilization of the long term care facility in the delivery of home health care services. As the facility currently has professional staff, dietary and recreational expertise and a non-professional staff trained in the treating of the geriatric patient, it seems logical that they could be utilized in an in-home setting. This would provide an additional source of in-home health care services. Further, the facility is already highly regulated by the Department of Health and the Department of Social Services and could provide a licensed vehicle both for the private pay and the medically indigent in the delivery of services and at the same time create a regulated, uniform reimbursement system wherein there would be greater control over the delivery of services than currently exists.

Long term health care in the United States has made rapid advancements in the last 10 years. However, it will continue to be an emotional and traumatic experience for the institutionalization of an individual who no longer can function in an independent setting. The physician can be extremely helpful in counseling the family and the patient by advising them that if the services of a facility are necessary, they can be assured they will receive quality care in safe surroundings delivered by people who are concerned with the patient's every need.

MEDICAL MISCELLANY

UCR PAYMENTS . . . An Iowa Blue Shield study of payments made under the UCR program (between 8/15/75 and 4/15/77 shows the monthly percentage of reimbursement (state-wide) to have run as high as 95% and to have never gone below 92%. Amounts authorized monthly in 1976 ranged from \$2.8 million to \$3.9 million. Two of four months in 1977 have exceeded \$4.0 million.

MEDICAID TRAVEL CHANGE . . . A Title XIX ruling was lifted May 1 which limited reimbursement to \$25 per month to cover transportation for Medicaid recipients to receive medical care. This provision applies to Medicaid recipients who must travel outside their home communities to receive necessary medical treatment.

SPECIAL RECOGNITION . . . Assistant Executive Vice President Tina Preftakes was accorded special commendation May 6 by the House of Delegates for 25 years of service to the Iowa Medical Society.

IMMUNIZATION LEGISLATION . . . Immunization against six communicable diseases will become a condition of entry into school (includes day schools) under legislation approved by the General Assembly. Controversial conscience clause was omitted in final version. Exemptions are now only for medical or religious reasons.

SPORTS MEDICINE . . . Planning for a 1978 Conference on the Medical Aspects of Sports began May 18 at a meeting of the IMS Committee on Sports Medicine. The every-other-year meeting for coaches, trainers, physicians, etc., is co-sponsored by the Iowa High School Athletic Association.



This July gathering of Iowa physicians for the 1977 Scientific Session promises to be a highlight in my "career" as an officer of the Iowa Medical Society. It is hoped all who attend will enjoy the effort put forth by the IMS Program Committee.

JAMES F. BISHOP, M.D.
IMMEDIATE PAST PRESIDENT
IOWA MEDICAL SOCIETY



**SCIENTIFIC SESSION
JULY 12, 13, 14, 1977
TELEMARK LODGE
CABLE, WISCONSIN**



THE 1977 SCIENTIFIC SESSION OF THE IOWA MEDICAL SOCIETY IS CO-SPONSORED BY THE UNIVERSITY OF IOWA COLLEGE OF MEDICINE. AS AN ORGANIZATION ACCREDITED FOR CONTINUING MEDICAL EDUCATION, THE UNIVERSITY OF IOWA COLLEGE OF MEDICINE CERTIFIES THAT THIS CME OFFERING MEETS THE CRITERIA FOR 12 CREDIT HOURS IN CATEGORY I OF THE PHYSICIAN'S RECOGNITION AWARD OF THE AMERICAN MEDICAL ASSOCIATION, PROVIDED IT IS USED AND COMPLETED AS DESIGNED.

IN ADDITION, THIS PROGRAM IS ACCREDITED FOR 12 HOURS OF PRESCRIBED CREDIT BY THE AMERICAN ACADEMY OF FAMILY PHYSICIANS.

PROGRAM COMMITTEE—

The 1977 Iowa Medical Society Program Committee is pleased to submit this three-day education program for your consideration. In the 12-hour period covered by the program, participants will be exposed to meaningful and diversified material which is aimed at helping them serve the people of Iowa with greater knowledge and skill. We sincerely hope you will attend and benefit from the program which has been arranged.



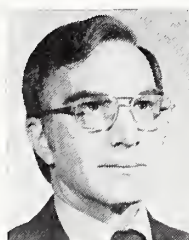
L. O. ELY, M.D.
DES MOINES
Chairman



R. M. CAPLAN, M.D.
IOWA CITY



W. B. HOFMANN,
M.D.
DAVENPORT



J. F. ROULES, M.D.
MEDIAPOLIS



J. F. VEVERKA,
M.D.
PRAIRIE CITY

TUESDAY, JULY 12

GENERAL SESSION

8:00 a.m.—WELCOMING REMARKS AND ANNOUNCEMENTS

JAMES F. BISHOP, M.D.
Davenport, Immediate Past President, Iowa Medical Society

8:15 a.m.—IS YOUR PET A HEALTH HAZARD?

KELLEY J. DONHAM, D.V.M.
Chief, Comparative Medicine Section, Department of Preventive Medicine, University of Iowa College of Medicine, Iowa City

8:45 a.m.—INFECTION CONTROL IN HOSPITALS AND NURSING HOMES

WILLIAM E. SCHECKLER, M.D.
Assistant Professor/Department of Family Medicine, University of Wisconsin Medical School, Madison

9:15 a.m.—DISEASES TRANSMISSIBLE TO MAN FROM ANIMALS OUTSIDE THE HOME

K. J. DONHAM, D.V.M.

9:45 a.m.—RECESS

DISCUSSION GROUPS

10:00 a.m.—CARDIOLOGY

"Current Understanding of the Pathophysiology of Sudden Death and Myocardial Infarction"

ROBERT S. ELIOT, M.D.
Director, Division of Cardiovascular Medicine, University of Nebraska Medical Center, Omaha
(Baldrige-Beye Memorial Lecture Sponsored by Scanlon Medical Foundation/IMS)

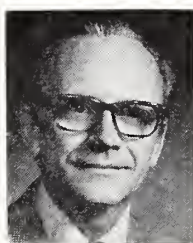
ENDOCRINOLOGY

"The Thyroid"

CHARLES ABBOUD, M.D.
Division of Endocrinology, Department of Medicine, Mayo Clinic, Rochester



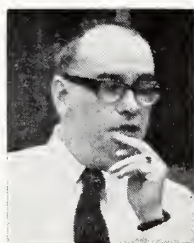
DR. ABBOUD



DR. ALBERTS



DR. DONHAM



MR. ENRIGHT



DR. ELIOT



DR. GOPLERUD

PROGRAM SPEAKERS—

CHARLES F. ABBOUD, M.D., Rochester, Minnesota—Department of Endocrinology and Internal Medicine, Mayo Clinic. Dr. Abboud received the M.D. degree from the Kasr-El-Aini Faculty of Medicine, Cairo University, Cairo, Egypt, in 1961. Dr. Abboud was certified by American Board of Internal Medicine in 1972 and is a diplomate of Subspecialty Board of Endocrinology and Metabolism. MARION E. ALBERTS, M.D., Des Moines, Iowa—Dr. Alberts is in the private practice of pediatrics. He received the M.D. degree from the University of Nebraska Medical School in 1948 and is certified by the American Board of Pediatrics. He is the Scientific Editor of the JOURNAL OF THE IOWA MEDICAL SOCIETY. KELLEY J. DONHAM, D.V.M., Iowa City, Iowa—Dr. Donham is Chief, Comparative Medicine Section, Institute of Agricultural Medicine and Environmental Health, University of Iowa College of Medicine. He received the D.V.M. degree in 1971 from Iowa State University. He serves on the Curriculum and Seminar Committees of his Department, the Public Health Committee of the Iowa Veterinary Medical Association, and on an Advisory Panel to the Department of Environmental Quality/State of Iowa.

MORTIMER T. ENRIGHT, Chicago, Illinois—Mr. Enright is Director of the Speakers and Leadership Program, American Medical Association. He holds degrees in psychology and the teaching of general social sciences. He has pioneered the use of videotape playbacks as a method of teaching successful speaking. ROBERT S. ELIOT, M.D., Omaha, Nebraska—Dr. Eliot is Professor of Medicine; Director, Cardiovascular Center and Division of Cardiovascular Medicine; and Monsour Medical Foundation Professor of Cardiovascular Medicine at the University of Nebraska College of Medicine. He received the M.D. degree from the University of Colorado. Dr. Eliot is certified by the American Board of Internal Medicine. CLIFFORD P. GOPLERUD, M.D., Iowa City, Iowa—Dr. Goplerud is Professor of Obstetrics and Gynecology at the University of Iowa College of Medicine. He received the M.D. degree from the University of Iowa in 1948, and is certified by the American Board of Obstetrics and Gynecology.

SPEECH TRAINING SEMINAR

MORTIMER ENRIGHT

Director, Speakers and Leadership Programs, Public Affairs Division, American Medical Association, Chicago

T. S. MAY, Ph.D.

Chairman, Radio-TV Division, Northwestern University, Chicago

Limited to 20 participants
Open to all for observation

BEHAVIORAL COUNSELING

"A Discussion on Behavioral Systems and Their Uses"

RICHARD SHROPSHIRE, M.D.

Associate Professor/Department of Family Medicine, University of Wisconsin Medical School, Madison

PHILLIPS KINDY, JR., M.S.S.W.

Clinical Instructor, Department of Medicine, University of Wisconsin Medical School, Madison

Noon—ADJOURNMENT

WEDNESDAY, JULY 13

DISCUSSION GROUPS

8:00 a.m.—CARDIOLOGY

"Contemporary Management of Myocardial Infarction by the Family Physician"

ROBERT S. ELIOT, M.D.

ENDOCRINOLOGY

"Adrenal Cortex: Update"

CHARLES ABBOD, M.D.

SPEECH TRAINING SEMINAR

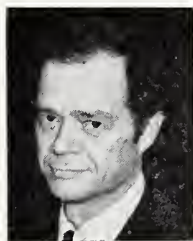
MORTIMER ENRIGHT

INFECTIOUS DISEASES

"Problem Cases of Participants and Antibiotic Utilization Review"

WILLIAM E. SCHECKLER, M.D.

Assistant Professor/Department of Family Medicine, University of Wisconsin Medical School, Madison



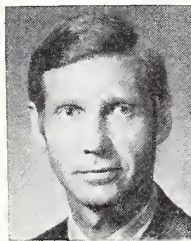
DR. JOHNSON



DR. KASIK



DR. MAY



DR. RAKEL



DR. SCHECKLER



DR. SHROPSHIRE

PROGRAM SPEAKERS—

CHARLES A. JOHNSON, M.D., Sioux City, Iowa—Dr. Johnson is a general surgeon in private practice. He received the M.D. degree from the University of Iowa College of Medicine in 1955, and is certified by the American Board of Surgery. His teaching activities include participation in the Family Practice Residency Program in Sioux City, as Chairman of the Surgery Department. JOHN E. KASIK, M.D., Iowa City—Dr. Kasik is Professor of Medicine at the University of Iowa College of Medicine. He received the M.D. degree in 1954, and the Ph.D. degree in 1962 from the University of Chicago. He is certified by the American Board of Internal Medicine, and Fellow of the American College of Physicians. T. S. MAY, Ph.D., Chicago, Illinois—Dr. May is Chairman of the Radio and Television Division of Northwestern University.

ROBERT E. RAKEL, M.D., Iowa City—Dr. Rakel is Professor and Head of the Department of Family Practice at the University of Iowa College of Medicine. He received the M.D. degree from the University of Cincinnati College of Medicine in 1958, and is a Charter Diplomate of the American Board of Family Practice, and currently serves as vice president. He serves on the Editorial Board of "Continuing Education for Family Physician," and is co-editor of "Family Practice" published by W. B. Saunders Co. WILLIAM E. SCHECKLER, M.D., Madison, Wisconsin—Dr. Scheckler is Assistant Professor and Coordinator of Internal Medicine, Department of Family Medicine and Practice, and Assistant Professor of Medicine at the University of Wisconsin Center for Health Sciences. He received the M.D. degree from the University of Pennsylvania School of Medicine in 1964, and is certified by the American Board of Internal Medicine. RICHARD W. SHROPSHIRE, M.D., Madison, Wisconsin—Dr. Shropshire is Associate Clinical Professor, Department of Family Medicine and Practice, University of Wisconsin Center for Health Services, and Director of the Residency Program in Medicine. He received the M.D. degree from the University of Iowa College of Medicine in 1953. He was in private practice for almost 19 years, and was one of several physicians who helped establish the Family Practice Program and Department at the University of Wisconsin.

10:00 a.m.—RECESS

GENERAL SESSION

10:15 a.m.—THE SCOPE OF FAMILY PRACTICE: FACT AND FICTION

ROBERT E. RAKEL, M.D., Moderator
Head, Family Practice Department, University of Iowa
College of Medicine, Iowa City

FAMILY PRACTICE PANEL

MARION E. ALBERTS, M.D.
Private Practice/Pediatrics, Des Moines

CLIFFORD P. GOPLERUD, M.D.
Professor, Department of Obstetrics and Gynecology,
University of Iowa College of Medicine, Iowa City

CHARLES A. JOHNSON, M.D.
Private Practice/Surgery, Sioux City

WILLIAM E. SCHECKLER, M.D.
Assistant Professor/Department of Family Medicine, Uni-
versity of Wisconsin Medical School, Madison

RICHARD SHROPSHIRE, M.D.
Associate Professor/Department of Family Medicine, Uni-
versity of Wisconsin Medical School, Madison

12:15 p.m.—ADJOURNMENT

THURSDAY, JULY 14

DISCUSSION GROUPS

8:00 a.m.—CARDIOLOGY

*"Influence and Management of Emotional Stress in Car-
diac Disease"*

ROBERT S. ELIOT, M.D.

ENDOCRINOLOGY

"Diabetes Update"

CHARLES ABBOUD, M.D.

SPEECH TRAINING SEMINAR

MORTIMER ENRIGHT

HOW TO CARE FOR THE PULMONARY CRIPPLE

JOHN KASIK, M.D.
Professor, Department of Internal Medicine, University of
Iowa College of Medicine, Iowa City

10:00 a.m.—RECESS

10:15 a.m.—REMAINING PROBLEMS IN PREVEN- TION OF Rh ISOIMMUNIZATION

CLIFFORD P. GOPLERUD, M.D.
Professor, Department of Obstetrics and Gynecology,
University of Iowa College of Medicine, Iowa City

10:45 a.m.—EMERGENCY CARE FOR RESPIRA- TORY DISTRESS

JOHN KASIK, M.D.
(Erskine Memorial Lecture)



MRS. MARJORIE LYNCH

11:45 a.m.—WHO IS RESPONSIBLE FOR BIG GOV- ERNMENT?

MRS. MARJORIE LYNCH

Associate Vice President for Extended Services, Univer-
sity of Alabama, Former Under Secretary of Health, Edu-
cation and Welfare

*Mrs. Lynch was HEW Under Secretary from 1965 to 1977
when she was named to her present position at the Uni-
versity of Alabama. Mrs. Lynch is a native of England
and came to this country in 1945. She served 10 years
in the Washington State Legislature before accepting the
first of several federal appointments.*

12:15 p.m.—CLOSING REMARKS

JAMES F. BISHOP, M.D.

12:20 p.m.—ADJOURNMENT

SPECIAL THANKS

The Iowa Medical Society extends appreciation to the following companies which have provided educational grants in support of the 1977 Scientific Session:

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Artistic Involvement of Physicians

RICHARD M. CAPLAN, M.D.

Iowa City

PHYSICIANS FREQUENTLY seem to have more-than-average interest and talent in the arts. Or so one often hears—there exists little or no solid data on this point. It is a psychological truism that positive traits tend to cluster together; and since physicians in general are bright, energetic and resourceful individuals, one might suspect they would have interest and talents in various aspects of artistic work or creativity.

A questionnaire study was conducted among a group of family physicians and a medical school faculty seeking to profile the participation of physicians in a variety of artistic or creative pursuits. An attempt was made to assess the occurrence of such involvement prior to professional training and afterwards, and also to indicate the level or intensity of such involvement.

The two groups included: a) family physicians attending a Refresher Course for Family Physicians at The University of Iowa, and b) full-time faculty members in the College of Medicine at The University of Iowa. These two groups were compared partly for the sake of general description, but also to learn whether any characteristics might be sufficiently different in the two groups as to have any potential role in selecting individuals more likely to seek careers in family practice than academic medicine.

METHOD

A questionnaire was distributed to the two groups. The family physicians attending the course numbered 223; the total full-time faculty members numbered 428. A portion of the questionnaire is shown. Similar sections covered involvement in writing, visual art, dance, theater,

Dr. Caplan is Associate Dean for Continuing Medical Education, University of Iowa College of Medicine, Iowa City, Iowa.

The involvement of family and academic physicians in artistic endeavors is examined in a study summarized here. The study assesses such activity in both pre- and post-professional training periods.

and the organization of creative presentations.

After the data were tallied, statistical analysis employed tests of differences between proportions¹ in order to establish which differences seemed unlikely to be random chance of the sampling process.

RESULTS

Ninety-one family physicians completed the questionnaire (41% return). Questionnaires were returned by 191 faculty members (45% return). Twenty-six percent of the responding faculty were faculty members who held Ph.D. degrees or the equivalent, rather than M.D. degrees. The data reported here include the faculty group as a whole.

Table 1 lists those activities in which the family physician group exceeded the faculty group at a statistically significant level (shown either as $P < .01$ or P between .01 and .05), and those activities in which the faculty group exceeded the family physician group. The information is further subdivided on the basis of whether the activities occurred prior to professional school or after professional school.

The graph in the figure indicates the profile of community size in which the respondents grew up. It was felt important to have some measure of community size as a possible indication of opportunity for the various forms of creative expression.

DISCUSSION

The data show clearly that the total amount of involvement in these activities after professional training was considerably less than earlier—a predictable phenomenon.

TABLE I

	Before Professional Training		After Professional Training	
Family physician group more than faculty group	$P < .01$	FP%/Fac%	$P < .01$	FP%/Fac%
Vocal solo—publicly w/o pay		28/15		
	$.01 < P < .05$		$.01 < P < .05$	
Marching band—publicly w/o pay		36/27	Vocal solo—publicly w/o pay	10/5
Concert band—publicly w/o pay		34/19	Vocal ensemble—publicly w/o pay	15/8
Concert band—publicly w/o pay and for personal satisfaction		10/5	Organizes festivals—publicly w/o pay	7/2*
Faculty group more than family physician group	$P < .01$	Fac%/FP%	$P < .01$	Fac%/FP%
Painting—personal satisfaction		13/5	Solo instrument—personal satisfaction	24/12
Theater acting—pers. satisfaction		19/7	Theater acting—personal satisfaction and publicly without pay	5/0*
Theater acting—publicly w/o pay		35/17		
Backstage crew—publicly w/o pay		16/6		
	$.01 < P < .05$		$.01 < P < .05$	
Ceramics/pottery—personal satisfaction		4/1*	Critical essay—publicly w/o pay	9/3*
Theater acting—personal satisfaction and publicly w/o pay		10/5	Other types of graphic art—personal satisfaction	5/1*

* These significance levels are only approximate due to the extremely small proportions involved.

ents indicated a total lack of involvement in any of the categories being assessed. But if there were individuals of either population whose personal histories were indeed devoid of any of these activities, they would likely not have returned the questionnaire.

A few instances of professional (i.e., paid) activity were reported, but the numbers were too small to permit statistically meaningful conclusions.

CONCLUSION

These descriptive data may in themselves be of some interest. It is not possible to state whether physicians as an occupational group either are or are not more talented or active in these creative pursuits, since I am unaware of data to compare these physicians or faculty members with the

population at large or the academic community. Although some statistically significant differences exist between the family doctors and the medical school faculty, the distributions overlap so much that it would not seem appropriate to attempt to use such personal habits or hobbies in selecting individuals for careers in either family practice or academic medicine.

ACKNOWLEDGMENT

Statistical analysis and consultation were kindly provided by Mark Albanese, M.A., of The University of Iowa College of Medicine's Learning Resources Unit.

REFERENCE

1. Downie, N. M., and Heath, R. W.: *Basic Statistical Methods*, Harper and Row, New York, Third Edition, 1970, pp. 188-193.

MEDICAL MISCELLANY

APPOINTED . . . Herbert Nelson, M.D., Iowa City, and Roger Shafer, M.D., Des Moines, are physician appointees to a newly-named Governor's Task Force on Mental Health.

NAMED . . . Dennis J. Walter, M.D., Des Moines, has been named recently to the State Board of Nursing Home Examiners.

USUAL AND CUSTOMARY . . . Payment of physicians on a usual, customary and reasonable basis began April 1 for services rendered in behalf of the Rehabilitation Education and Services Branch of the Department of Public Instruction (Vocational Rehabilitation) and the Disability Determinations Unit (OASI). A review mechanism will be available where necessary.



Editorials

M. E. ALBERTS, M.D., Scientific Editor

1977 SCIENTIFIC SESSION

July 12, 13 and 14 should be circled on the calendar as special days for you and your family. Fishing may be excellent, the swimming will be refreshing; tennis or golf may beckon. In addition, there will be a topflight educational expe-

rience covering three half days. Telemark Lodge in Cable, Wisconsin extends its hospitality to the IMS for the 1977 Scientific Session. Further information on the scientific program is presented on pages 210A-D of this issue of the JOURNAL. The attendance looks good. Check with IMS Headquarters if you would like to attend.

FOOD FADS: SPECIAL DIETS

A recent report from the Committee on Nutrition of the American Academy of Pediatrics¹ expressed concern over the increase in various nutritional practices which may jeopardize the health of children. On the other hand, another publication promotes a specialized feeding program to prevent hyperactivity in children.²

Cholesterol has been implicated in cardiovascular disease. Similarly, sugar has taken its lumps (no pun intended). It seems it may be just plain unhealthy to eat at all if we want to stay alive and well. Yet, there is much over which we should be concerned when we consider present day foods, their preparation, and manner of consumption.

Dietary restrictions often have a religious base, as has been the case with beliefs of the Jewish faith. In recent years many fads have been promulgated based on life style, morality and ecologic concerns. The Committee emphasizes

that beneficial claims made for various special diets must be more completely subjected to critical, scientific evaluation.

Vegetarian diets vary in their content. Some are vegetables only, while other include milk and/or eggs along with the vegetables. Most vegetarian diets are so high in bulk, however, that they may not meet caloric needs. Yet, many population groups have practiced these dietary measures on a long-term basis with excellent results.

The Zen macrobiotic diet is considered the most dangerous of the current diets for growing children. This rigid dietary regimen, spiritually promoted, leads to a gradual elimination of animal products, fruits and vegetables, ultimately to the point of cereals only. Consequently, the caloric needs are not met, and ultimately scurvy, anemia, hypo-proteinemia, hypocalcemia, and emaciation may ensue. Unfortunately, proponents of this diet often engage in self-treatment of disease and do not seek medical consultation when the ravages of the diet become evident.

Organic foods are promoted as natural foods uncontaminated by pesticides, herbicides, inorganic fertilizers, hormones, antibiotics, or other synthetic additives or preservatives. Since there

1. Committee on Nutrition, American Academy of Pediatrics: Nutritional aspects of vegetarianism, health foods, and fad diets. *Pediatrics* 59:460-464, Mar. 1977.

2. Stevens, L., Stevens, G. E., and Stoner, R. B.: How to feed your hyperactive child. Garden City, New York, Doubleday & Co., Inc., 1977.

is no test to differentiate organically grown and organically processed food from commercial products, it would seem in many instances the consumer must exercise a considerable degree of faith. Long-term studies have failed to demonstrate a nutritional superiority for organically grown crops. Poor soil yields poor crops, not poor food. However, pesticides, and hormones, and antibiotic residue in foods may present a valid concern. Likewise, various additives should be under close scrutiny, as the FDA seems intent upon in recent months. Organic food costs more; the consumer pays the price while relying upon the integrity of the producer and distributor.

Recent reports have advocated diets free of salicylates and additives in the management of hyperactive children. In 1973, Dr. Ben Feingold suggested these substances to be involved in the hyperactive state demonstrated by some children. He insisted that even an 80-90 percent compliance with an additive-free, salicylate-free diet could

lead to failure; a single infraction would result in recurrence of symptoms. There is not wholehearted acceptance of this program for treating hyperactive children. It is a difficult diet to follow in a complete fashion, because so many of our popular foods do contain artificial colorings and flavorings as additives. The more popular foods in the diet of children must be eliminated—most ice creams and puddings, luncheon meats, hot dogs, some potato chips, chocolate, gum, soda pop, and so on. Also, such foods as apples, raisins, cucumber pickles, grapes and tomatoes are not permitted.

The entire concept is interesting. More study is necessary. Any way to prevent hyperactivity in a child has to be a blessing. Supposedly we are what we eat. Care in considering diet is obviously important. Fads must be eliminated when they are that only, but when based upon a valid basis certain restrictions are necessarily important.—M.E.A.

A JAMA ADVERTISEMENT

Concern has been expressed to us about an advertisement which appeared in the November 8, 1976, issue of JAMA. A full-page advertisement in bold print proclaimed that "Preparation-H®" (Whitehall Laboratories) is "—no mere palliative or lubricant. The formula contains ingredients that help reduce the swelling of hemorrhoidal tissues due to inflammation or infection." The advertisement does not list the ingredients of the formula.

THE MEDICAL LETTER, a periodic bulletin, enlightens us that the active ingredients are "live yeast cell derivative, supplying 2,000 units skin respiratory factor per ounce of ointment; shark liver oil, 3.0%; Phenylmercuric Nitrate 1:10,000

in a specially prepared rectal base." THE MEDICAL LETTER further states there is no acceptable evidence that any of these ingredients, alone or combined in Preparation-H, can reduce inflammation, cure infection, or shrink hemorrhoids.

We have a dilemma. The appearance of the advertisement in JAMA could connote AMA approval. Other informational sources imply that the product is not what the sales promotion would have us believe. Why would such an advertisement be accepted by JAMA? Is there more to the ointment than what we are aware of? Is THE MEDICAL LETTER unaware of the effects of the preparation? Is JAMA opening its advertisement pages to any source of revenue?

We desire to know what comments the physicians of Iowa might have about this advertisement.—M.E.A.

A GOOD DEAL

Membership in the Iowa Medical Society has various tangible and intangible benefits. These are often taken for granted and given little thought.

For example, there is a significant cost savings through participation in the Society's group insur-

ance coverages. Take a 45-year-old physician who participates in three of the group coverages (life, accident and disability and office overhead): He would save between \$818 and \$896 in premiums annually over that which he would pay for the same coverages to two other leading insurance companies. Over one thousand IMS members do participate in one or more of the programs.

The Question Box

MEDICAL HISTORY

Iowa's medical history is laced with interesting episodes. This history should be recorded for succeeding generations. Here Paul Huston, M.D., Iowa City, and W. H. Longworth, M.D., Ames, comment on this topic. Dr. Huston and Dr. Longworth are co-chairmen of the IMS Historical Committee.

What is the goal of the IMS Historical Committee?

To see recorded medical histories of all Iowa counties. In less populated areas, two to four counties might be combined. Further grouping might be possible, say for a single councilor district. We believe the emphasis should be on local medical history before any attempt is made at a new state medical history, such as was done by Dr. Bierring in 1950 and by Dr. D. S. Fairchild in 1918 and 1927. An accurate and complete state medical history is dependent on county records.

Is it important for the average physician to have an interest in the history of medical care in and around his practice setting?

Yes. Younger physicians have duties which take much of their time. But they'll be grateful to those who record the medical history of their area. Knowing what our predecessors achieved is reason enough to know our history; we can learn much from them if there is an accurate record of the past. As Osler said, ". . . you young men of this generation . . . will do great things, you will have great victories, and standing on our shoulders, you will see far. . ."



DR. LONGWORTH



DR. HUSTON

What help can the Historical Committee give to the physician who wants to look into local medical history?

Please see the guidelines or "how to" suggestions developed by the Historical Committee. We will be happy to receive and answer questions. We urge research by a local physician historian. We are working with professional historians to develop a system for the storage and cataloguing of county and state material. We hope to disclose further information about this soon.

The Iowa Medical Society had its origin in 1850. In that time great medical progress has been made. Are our Iowa historical records adequate to convey this story of progress to our succeeding generations?

Any type of history is an incomplete, continuing story. Current rapid changes in medicine are being better recorded and can be more easily retrieved. Earlier changes, in the latter 1800's and early 1900's, are not so well recorded. We believe this early local medical history should be written—or even taped—before it is forever lost.

GUIDELINES FOR THE PREPARATION OF LOCAL MEDICAL HISTORIES

*The Iowa Medical Society Historical Committee has prepared these suggestions
for use in preparing local medical histories.*

1. County medical histories are preferred. In less populated areas, two to four counties may be combined.

2. County medical historians may be retired or semi-retired physicians, a physician and his wife, or a physician's widow. Writing must be accurate but not necessarily scholarly; the necessary editing can be accomplished with outside help. The objective is to get a history written—or taped—rather than have it lost forever.

3. Include brief histories of all past and present hospitals in the area.

4. Include accounts of pioneer medical practice—note limitations, hardships, variations in medical training, etc. Consult records of early organizations of doctors.

5. Consider brief general histories of county, townships, settlements, noting population movement into the area.

6. Research old available photographs. Identify individuals in group pictures. Photos of early hospitals add interest.

7. Consider brief alphabetically-arranged sketches of physicians up to an appropriate point in history. The State Board of Medical Examiners can help in validating information. Include name, year and place of birth, education, further training, military service, beginning year of practice in county, year of any move, retirement and death. Use can be made of standard abbreviations. Larger counties will find this listing difficult and impractical.

8. Insertion of osteopathic physicians and surgeons is optional.

9. Include anecdotes, unusual events, humorous or tragic episodes which illustrate the doctor-patient relationships, old prescriptions, etc.

10. Interview older physicians with a tape recorder, then transcribe and edit their recollections.

11. Use various sources for information: local libraries; the State Medical Library in the Historical Building at the Statehouse; the U. of I. College of Medicine Library and other library facilities in Iowa City, local newspapers, the Iowa Medical Society, records of county medical societies and local hospitals, early medical directories and membership rosters, different medical journals and periodicals; Division of Licensure and Certification, Board of Medical Examiners, State Department of Health (no licensure occurred until 1886); books such as county histories published by Union Publishing Company, state medical histories by Dr. David Fairchild in 1918 and 1927, and by Dr. Walter Bierring in 1950. The IMS has a bibliography of books and periodicals which can be made available on request.

12. Review any publications of a local historical society.

13. Financing of a local medical history usually needs to be cooperative—with possible support from the county medical society, the IMS, local historical society, other local organizations, businesses, physicians and other individuals. Sale of the finished product is not to be expected.

14. Place completed county medical histories in several libraries and with the Iowa Medical Society.

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About IOWA Physicians

Drs. Paul From and **John W. Olds**, Des Moines, and **Dr. Donald D. Brown**, Iowa City, were named fellows of American College of Physicians at a recent meeting of the College's Board of Regents in Dallas, Texas. . . . **Dr. Jack Moyers**, professor and head of the Department of Anesthesia at U. of I. College of Medicine, is new chairman of the Residency Review Committee for Anesthesiology of the Liaison Committee on Graduate Medical Education. Dr. Moyers is also president-elect of the American Society of Anesthesiologists. . . . **Dr. John Thornton**, longtime Lansing physician, spoke at ribbon cutting ceremonies for new Lansing nursing home, Thornton Manor, named in honor of Dr. Thornton. . . . **Dr. Dale Harding**, Eagle Grove, recently attended a symposium on cancer chemotherapy at Hahnemann Medical College in Philadelphia, Pa. . . . **Dr. John Lee** will open a pediatric practice in Keokuk in July. Dr. Lee received his medical education at Seoul National University in South Korea. After moving to the United States, he completed a one-year internship at St. Margaret Hospital in Pittsburgh, Pa.; a two-year residency in family practice at Louise Obici Memorial Hospital in Suffolk, Virginia; and a pediatric residency at the New Jersey Medical School in Newark, New Jersey. . . . **Dr. Kenneth Caldwell**, Montezuma physician for 16 years, closed his office June 1 to join the University of Northern Iowa Student Health Center. Dr. Caldwell received the M.D. degree at U. of I. College of Medicine and interned at Mercy Hospital in Cedar Rapids.

Dr. Raymond R. Rembolt, director of University Hospitals School for Severely Handicapped Children, will retire June 30. Dr. Rembolt received the M.D. degree at University of Nebraska School of Medicine. He was in private practice in Lincoln, Nebraska prior to joining the U. of I. faculty in 1948. . . . **Dr. J. V. G. Angel**, Council Bluffs, has been promoted to Active Fellowship in the Amer-

ican College of Allergists. . . . **Dr. James Bishop**, Davenport, immediate past president of the Iowa Medical Society, was guest speaker at the recent annual meeting of the Iowa Hospital Association. . . . **Dr. Roger W. Boulden**, Lenox, attended a recent spring refresher course of the Minnesota Academy of Family Physicians in Bloomington, Minnesota. Dr. Boulden, president-elect of the Iowa Academy of Family Physicians, represented the Academy. . . . **Dr. James A. Clifton**, Roy J. Carver professor and head of Department of Internal Medicine at U. of I. College of Medicine, was recently installed as president of the American College of Physicians. Dr. Clifton is the first Iowa physician to preside over the 37,000 member organization. . . . **Dr. Jack D. Fickel**, Red Oak, is one of four rural physicians selected to participate in the second Nebraska Methodist Hospital Radiologic Fellowship in Omaha.

Dr. Karl E. Jauch has been named associate program director for the Black Hawk Area Family Practice Residency Program in Cedar Falls. A LaPorte City family practitioner since 1955, Dr. Jauch received the M.D. degree at University of Illinois College of Medicine and is board certified by American Board of Family Practice. Dr. Jauch will assist **Dr. Charles A. Waterbury**, director, in planning and co-ordinating the educational portion of program; supervising residents; leading medical conferences and seminars; and seeing patients at Family Practice Center. . . . **Drs. Don Boyle, G. J. McGowan, J. T. Baller, Bruce Bedell, A. D. Blenderman, Robert Boldus, Michael Chandra, Walter Eckman and Barry Knapp**, all Sioux City physicians, participated in recent two-day emergency medicine seminar in South Sioux City. Others on the program were: **Dr. Michael Abrams**, director of emergency and ambulatory care services at Broadlawns Polk County Hospital in Des Moines; **Dr. Ronald Eckhoff**, deputy commissioner of health for Iowa; and

Dr. Charles Griffin, director of emergency services at Finley Hospital in Dubuque. . . . **Dr. Walter Block**, Cedar Rapids, was the guest speaker at recent meeting of Marion-East Cedar Rapids Rotary Club. . . . **Dr. Charles H. Read**, professor of pediatrics at U. of I. College of Medicine, was a program participant at an Emmetsburg workshop on "Coping with Diabetes Mellitus." Designed for physicians and allied health professionals, the workshop was sponsored by Iowa Lakes Community College.

Dr. Ronald K. Grooters has joined **Drs. Louis D. Rodgers, Robert L. Kollmorgen** and **Bernard D. Monw** in the practice of cardiac and chest surgery in Des Moines. . . . During recent homecoming activities at Marycrest College in Davenport, **Dr. John F. Collins**, Davenport physician, was presented an honorary membership in the alumni association. Dr. Collins is a former president of the Mercy Hospital medical staff and has practiced medicine in Davenport for 16 years. . . . **Dr. Fred Rolfs**, Aplington, was guest speaker at recent banquet sponsored by the Aplington Jaycees. . . . **Dr. R. L. Bendixen**, Denison, conducted a recent scientific meeting of Central Plains Chapter of the Flying Physicians Association in Kansas City, Missouri. Two Iowa physicians were program participants—**Dr. Charles Bendixen**, brother of the Denison physician, spoke on "Cancer, VD and Herpes Ring," and **Dr. Boynton Woodburn**, Des Moines, spoke on "Intravenous Regional Anesthesia." . . . **Dr. Anthony C. Catipay**, Clinton, recently attended a three-day course on laparoscopy, hysteroscopy and fetoscopy at Northwestern University Medical Center and Prentice Women's Hospital in Chicago. . . . **Dr. Sam T. Donta**, associate professor of medicine at U. of I. College of Medicine, was guest speaker at recent meeting of the Woodbury Medical Society. His topic "The New Antibiotics."

Dr. David MacMillan, Waverly, spoke on care of diabetics at recent meeting of Bremer-Butler Area Diabetes Unit. . . . **Dr. Joseph Callaghan**, Decorah, was recently elected president of the Iowa Academy of Surgery. A native of Ireland, Dr. Callaghan was named a Fellow of the International College of Surgery in 1976. . . . **Dr. Robert Kuhl**, Creston, spoke on bicycling at recent meeting of Creston Kiwanis Club. Dr. Kuhl participated in 1976 RAGBRAI bicycle trip across Iowa. . . . **Dr. Harry Mahannah**, member of Southern Iowa Mental Health Center staff, has

moved his office from Bloomfield to Ottumwa. . . . **Dr. R. D. Eckhoff**, head of the community health division of the Iowa State Department of Health, was guest speaker at recent meeting of Newton Kiwanis Club. Dr. Eckhoff spoke on duties and services of the health department.

DEATHS

Dr. Jay C. Timmerman, 41, Iowa City dermatologist, died April 15 at Mercy Hospital. Dr. Timmerman received the M.D. degree at U. of I. College of Medicine; interned at Youngstown, Ohio, and completed his residency in dermatology at University Hospitals in Iowa City. Dr. Timmerman was a member of Alpha Omega Alpha and a Fellow of the American Academy of Dermatologists.

Dr. Arthur J. Ross, Jr., 85, retired Perry surgeon, died April 27 at the Dallas County Hospital. Dr. Ross received the M.D. degree at the University of Nebraska School of Medicine. A World War I veteran, Dr. Ross practiced surgery in Perry from 1940 until his retirement.

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Each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); and 25 mg phenobarbital in the immediate release layer.

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

See next page for brief summary.

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Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

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These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to one-quarter Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

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Full information is available on request.

Morbidity Report for April, 1977

Disease	April 1977	1977 to Date	1976 to Date	Most April Cases Reported From These Counties
Amebiasis	13	25	17	Guthrie, Boone
Brucellosis	3	4	—	Dubuque
Chickenpox	1378	6433	7557	Scattered
Conjunctivitis	419	1333	1009	Clayton, Lee
Encephalitis	2	2	—	Dubuque, Mitchell
Erythema infectiosum	12	35	81	Winnebago
Gastrointestinal viral infection	2715	14547	14672	Lee, Monona, Webster
Giardiasis	7	24	13	Boone
Hepatitis, A (infectious)	12	32	45	Scattered
Hepatitis, B (serum)	6	33	25	Scattered
Impetigo	78	300	375	Scattered
Infectious mononucleosis	173	545	610	Scattered
Influenza—lab confirmed	20	65	143	Scattered
Influenza-like illness	4168	38311	37209	Scattered
Meningitis bacterial	1	2	—	Dallas
type unspecified	2	4	—	Linn, Muscatine
Mumps	232	1144	911	Linn, Scott
Pediculosis	46	114	206	Scattered
Pinworms	6	20	9	Scattered
Pneumonia	123	450	609	Scott
Rabies in animals	19	25	21	Scattered
Rheumatic fever	6	22	14	Chickasaw, Davis, Decatur
Ringworm body	33	152	140	Black Hawk
scalp	1	4	—	Marshall
Rubella (German measles)	37	122	12	Polk
Rubeola (measles)	796	2773	15	Clayton, Dubuque, Polk
Salmonellosis	10	45	33	Scattered
Scabies	108	483	188	Black Hawk
Shigellosis	2	15	11	Black Hawk
Streptococcal infections	1241	6782	8704	Scattered
Tuberculosis total ill	6	30	39	Polk
bacteria positive	3	23	18	Polk
Venereal diseases gonorrhea	544	1898	2135	Black Hawk, Polk, Scott
syphilis	41	131	123	Scattered

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
Cytomegalovirus—2; Herpes Simplex—20

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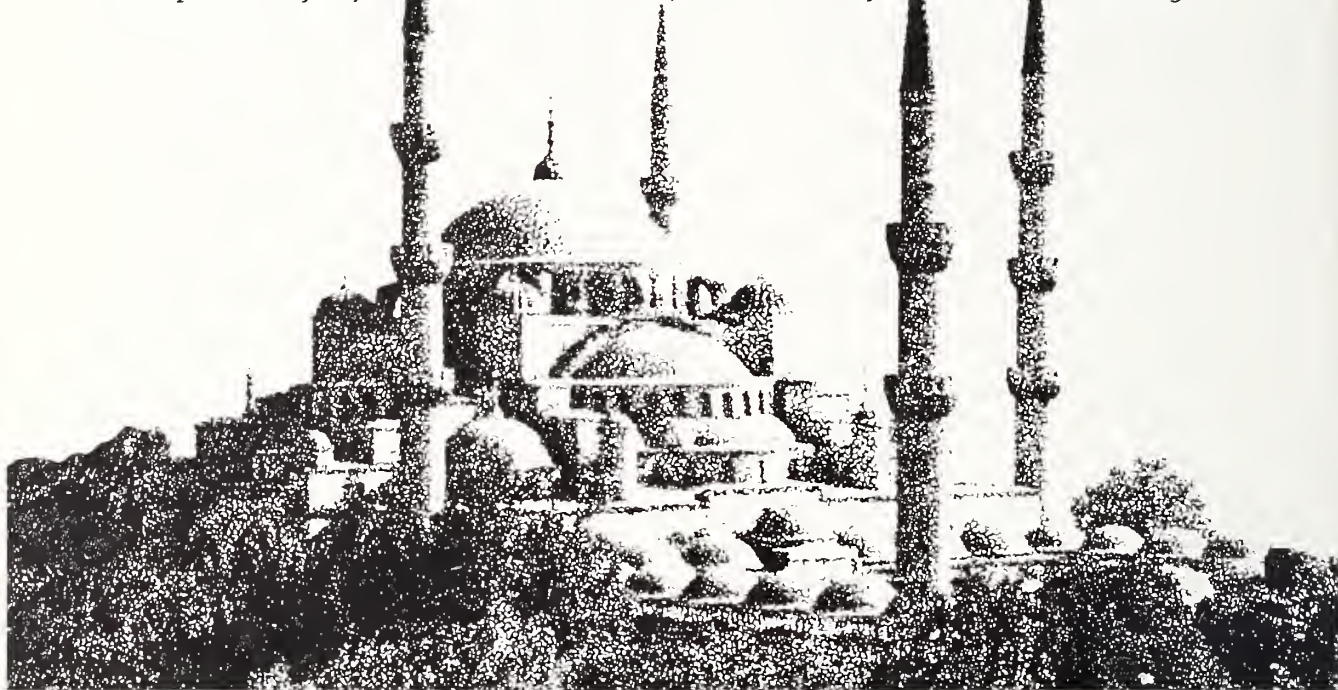
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Medical Assistants



by BETTY EHLERT, CMA-A

1977 STATE MEETING—MASON CITY

One hundred and twenty-seven medical assistants attended the 21st annual meeting of the American Association of Medical Assistants, Iowa State Society, Inc., April 15, 16 and 17, at the Sheraton Motor Inn, Mason City. Florence Wagner, convention chairman, was assisted by Marcia Steinberg and the entire Mason City chapter. They are to be commended for a successful meeting, which included a lovely welcoming party on Friday evening.

The theme, "LIGHT YOUR WAY WITH LEARNING," was reflected during the weekend as members attended an excellent educational session planned by Tenora Meyer, CMA-A, and Jo Popenhagen.

Members were welcomed by Mason City Chapter President Arlys Wirtjes; Robert Powell, M.D., President, Cerro Gordo County Medical Society; Mason City Mayor Ken Kew; Mr. Evan Nolte, who represented the Chamber of Commerce, and the Reverend Fred Barrick, who gave the invocation.

Leanna Rist, CMA-A, Des Moines, 1976-77 State president, presided at the House of Delegates. New officers for the coming year are:

President: Margaret Porter, CMA-AC, Cedar Rapids, employed by Donald D. Weir, M.D.

President-Elect: Jean Gold, Davenport, employed by Urological Associates, P.C.

Vice President: Shirley Anderson, Sioux City, employed by Drs. Joe M. Krigsten and M. D. Grossman

Secretary: Dianne Menneke, CMA-A, Des Moines, employed by James M. Caterine, M.D.

Treasurer: Nina Kline, LPN, CMA, Waterloo, employed by Cecil Seibert, M.D.

A program on "New Advances in Ophthalmology and X-ray" was presented by John B. Dixon, M.D., Mason City, and B. J. Broghammer, M.D., Mason City. Richard Caplan, M.D., Iowa City, discussed "Patient Health and Education"; A. J.

Wolbrink, M.D., "Orthopedic Surgery in Korea"; and Robert Dinapoli, "Office Neurology." A Bio-Feedback demonstration was presented by Judy Nau of the Mental Health Center in Mason City. CEUs were earned by certified medical assistants.

A spring fashion show was enjoyed at the Saturday luncheon. Mrs. C. O. Adams, president, Iowa Medical Society Auxiliary, was the "Theme Speaker."

Jeanne Green, CMA-A, Davenport, national president-elect, represented the national association and discussed her duties and schedule for the coming year. She presented a certificate of appreciation from the AAMA, Iowa State Society, to Tenora Meyer, CMA-A, for serving five years as Iowa Medical Society journal correspondent.

E. D. Kennedy, M.D., was master of ceremonies at the Saturday banquet. The Women's Chorus, River City Arrangement, provided delightful musical entertainment. The installation of new officers was led by Installing Officer Jeanne Green, CMA-A, AAMA president-elect, and a reception honoring newly installed State President Margaret Porter, CMA-AC, Cedar Rapids, followed.

The 1978 state meeting will be in Cedar Rapids.



1977-78 OFFICERS—Left to right are Nina Kline, LPN, CMA, Treasurer; Shirley Anderson, Vice President; Margaret Porter, CMA-AC, President; Leanna Rist, CMA-A, Immediate Past President; Jean Gold, President-Elect, and Dianne Menneke, CMA-A, Secretary.

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FAMILY PHYSICIAN WANTED—Young group of four doctors, three fully active, desire young associate in Winterset, Iowa. Newly remodeled and expanded office. JCAH approved hospital. Good proximity to Des Moines (35 miles) for referrals, etc. Expanding practice with plenty to do. Competitive salary. No purchase of partnership needed after first year. Contact Nelson H. Chesney, M.D., 115 West Court, Winterset, Iowa 50273. Phone 515/462-1040.

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FOR SALE—Every office reception room should have a copy of "Unseen Battles of the Night" by S. W. Barnett, M.D., Cedar Falls, Iowa. Send check for \$7.50 to Box 485, Cedar Falls, Iowa 50613 and a copy will be sent postpaid.

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President's Page

The statistics of the recently-adjourned regular session of the Iowa General Assembly are a bit mind-boggling. There were 1,047 bills submitted for consideration. Of these, 633 originated in the House, and 414 were introduced in the Senate. Of the total, 165 passed both chambers.

It hardly seems possible a state with Iowa's characteristics could need (and we don't) 1,047 changes or additions to our Code of Law. But legislative trends suggest the volume will go up even more.

What health measures received full Assembly approval? A family practice residency appropriation of \$900,000. A \$74 million Medicaid allocation. A compulsory immunization law for school entrants. A certificate of need law which excludes physicians' offices except where there is a single piece of equipment costing over \$150,000. A continuing education and professional discipline law giving new responsibilities to the Board of Medical Examiners.

An additional group of health-related bills passed either the Senate or the House. These await possible 1978 consideration across the rotunda. Other health proposals remain as introduced. These generally have been assigned to a subcommittee for study and recommendation.

We have seen interim activity (in summer and fall) increase steadily in recent years. Still this period offers the best opportunity for back-home conversation between lawmaker and constituent. You are urged to contact your senator and representative in the next several months. Get acquainted with them (if you are not already). Assure them of your intention to follow the 1978 actions of the Assembly.

The IMS Committee on Legislation will be at work during the interim to determine its 1978 strategy. Please contact Society Headquarters if you want specific background information on any bill or bills.



L W Swanson M.D.

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THE JOURNAL OF THE **IOWA** **medical** **society**

VOL. 67 No. 7

JULY 1977

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Annual Session of 1977 House of Delegates





LEFT PAGE—Upper: (Left) President and Mrs. J. F. Bishop in a happy mood with IMS Judicial Council Chairman J. E. Tyrrell, Manchester, right. (Right) President-elect and Mrs. L. W. Swanson visit with IMS Secretary W. R. Bliss, Ames, right. Upper Middle: (Left) Reference Committee on Articles of Incorporation and By-Laws: Chas. Jons, Ames; G. L. Neligh, Council Bluffs; K. A. Garber, Corydon; K. D. Dolan, Iowa City, and C. L. Dagle, Ft. Dodge. (Right) K. E. Lister, Ottumwa, right, receives 1977 IMS Merit Award from Board Chairman A. J. Havlik. Lower Middle: (Left) Reference Committee on Reports of Officers: G. J. Hegstrom, Ames; J. A. Broman, Maquoketa; Don Newland, Des Moines; G. J. McGowan, Sioux City, and J. W. White, Dubuque. (Right) IMS Board of Trustees, seated from left, J. H. Kelley, Des Moines, trustee; L. W. Swanson, Mason City, president; R. S. Gerard, Waterloo, president-elect, and R. T. Melgaard, Dubuque, vice-president. Standing, T. A. Burcham, Des Moines, treasurer; Hormoz Rassekh, Council Bluffs, trustee; W. R. Bliss, Ames, secretary, and A. J. Havlik, Tama, Trustee. Lower: (Left) Reference Committee on Legislation and Medical Service: Janet Wilcox,

Iowa City; W. C. Rosenfeld, Mason City; R. P. Ferguson, Lake City; G. E. Michel, Cherokee, and W. J. Robson, Cedar Rapids. (Right) A. J. Havlik presents AMA-ERF check to J. W. Eckstein, U. of I. medical dean. RIGHT PAGE—Upper: From left are several who addressed the 1977 House: IMS President Bishop, AMA President Richard Palmer, IMS President-elect L. W. Swanson, and Blue Shield Board Chairman E. E. Linder. Middle: (Left) Tina Preftakes, Assistant Executive Vice-President, is recognized for 25 years' IMS service. (Second Left) V. L. Schlaser, Des Moines, right, receives past-president plaque from President Bishop. (Second Right) New IMS Life Members, from left, A. R. Wanamaker, Hamburg; J. M. Bruner, Des Moines; C. A. Nicoll, Panora, and P. D. Knott, Sioux City. (Right) L. W. January, Iowa City, U. of I. professor of internal medicine, is 1977 recipient of Ben T. Whitaker Interstate Postgraduate Teaching Award. Lower: From left, Banquet Speaker State Senator Elizabeth Shaw; Auxiliary President Velma Adams; IMS Medico-Legal Chairman C. H. Denser, Jr., and IMPAC Chairman T. E. Kiernan. The 1977 IMS House of Delegates met in Des Moines May 6 and 7.

Medicine's Hatful of Crickets

JAMES F. BISHOP, M.D.
DAVENPORT

Today's health care milieu is beset by many problems and pressures—rising costs, governmental incroachment, liability threats. Retiring Society President Bishop urges medicine to maintain a strong voice in behalf of patients and the profession itself.

THIS HAS BEEN a busy year for all of us and there seems little reason to expect the next one will be any different. The problems always seem to be as numerous and busy as a hatful of crickets. No sooner do we swat one than another comes hopping by.

One of the largest crickets we have to contend with is the cost of health care. Like inflation, it seems to swell despite all efforts to bring about some kind of order. Statistics are slippery things, often trained to do the bidding of their masters. However, there seems little dispute about the statement that health care consumes 8.5 to 9% of the Gross National Product. The promise is that it will continue to rise.

You have, perhaps, heard the declaration, now almost considered a cliché, that in 1975 General Motors paid more to the Blues for its employees' health insurance than it did to U.S. Steel for metal for its cars. Somebody said the other day there is nothing strange about that. They don't seem to put much steel in cars any more anyway.

However that may be, I have to wonder just what is sheltered under this broad umbrella of health care costs. Is it only the charges of medical and osteopathic physicians and surgeons and the related hospital bills? Does the statistic embrace the services of dentists, podiatrists, optometrists, and psychologists? Somewhere in that

8.5% do we find the spine rattling of the chiropractor, the hydraulics of the colonic irrigator, the mystic ministrations of the naturopath, and the impalement of acupuncture?

Does the cost of health care include all the over-the-counter purchases of pain killers, sleep inducers, laxatives, Preparation H, the millions uselessly spent for vitamins, the pathetic expectations from vitamin E and copper bracelets for arthritis?

We must keep in mind, too, the enticing and expensive promises of the health food stores and of Laetrile, the cancer cure. Laetrile is likely to be more expensive than Krebiozen, the cancer cure of 25 to 30 years ago about which the same kind of controversy swirled.

MEDICAL PROGRESS

Much of the increased cost of care results from the almost unbelievable speed of medical progress. The complicated and sophisticated contraptions used now for diagnosis and treatment are costly to design, to build, and to operate. The simple and inexpensive things have long ago been done. As medicine pushes its frontiers of knowledge, the journey becomes more complicated and expensive.

The one sure way to stop this part of the rising costs is to retreat to a safe and familiar valley and to venture up the mountains no more. But, man is curious and venturesome and it is unlikely he will ever change.

If, then, the expensive technology is to continue, perhaps the answer might lie in limiting access to these benefits; to pick and choose and decide who may have them.

Is it fair to spend \$10,000 for one kidney transplant or one coronary by-pass when the same money could benefit a greater number? Should a very elderly person have a hip replacement so he or she can totter around for another year or so?

These operations are heroic measures. We have for some time stopped heroic measures where the battle is obviously lost and to persevere only pro-

These remarks were presented on May 6 by Society President J. F. Bishop, M.D., at the opening session of the 1977 Annual Meeting of the Iowa Medical Society House of Delegates.

longs dying. Are we ready to withhold heroic measures because they cost too much? I don't want it that way and neither do you, but the critics keep talking about money and they must understand where the saving of dollars may lead.

CONTAINING COSTS

There are things we can do to help contain at least part of the rise in costs. Some we are already doing with peer review and utilization committees. We can show restraint in increasing fees. This we are doing now. At a recent meeting, the president of Blue Shield told us that physicians, in Iowa at least, are not raising their charges. We can order laboratory and x-ray procedures with a rifle instead of a shotgun. We can be ever on the lookout for the patient who can safely be sent home from the hospital a day sooner.

The one participant in the health care cost picture we have trouble doing something about is the patient. Or, as he is known today, the consumer. He is inclined to use health care services more than he needs to, but he still has to be seen. Even the most chronic complainer does sometimes have something the matter with him.

We should understand, too, the advantages of our present system which might be termed "private enterprise socialism." Through the process of hard American bargaining, the labor unions have won for their members a growing list of so-called fringe benefits which include medical and hospital insurance. These benefits are paid for by the public through increased prices for the goods and services involved, prices arrived at through the competition of the marketplace.

We must do all we can to preserve and protect this system. It makes provision for millions of our citizens to have health care, it is more efficient and economical than any governmental type of socialism, and it is of practical and material benefit to us.

Few of our patients could pay from their own resources the charges paid in their behalf under this private enterprise socialism. If, because of poor judgment, we contribute to the breakdown of this system, we cannot lament if the Kennedy-Corman bill comes to center stage from where it now waits in the wings.

This thought of the Kennedy-Corman bill for a completely nationalized health plan brings up the matter of the AMA's sponsorship of a bill for national health insurance. We have been receiving letters from a number of state medical so-

cieties asking that Iowa support an effort to reverse the AMA position. The arguments on both sides are sincere and persuasive.

IOWA'S POSITION

In the past this Iowa House of Delegates has supported the AMA position on national health insurance. The Iowa delegation to the AMA and Board of Trustees have sustained the philosophy that if we want to sit in on the game, we had better draw some cards. Unless you give other instructions at this meeting, Iowa will hold steady as she goes.

For the last two years, and indeed up until the past few months, there have been great exertions by this Society to bring the malpractice insurance chaos down to manageable confusion. As you have heard, it now seems to be there, and insurance companies that once picked up their skirts and fled the market have come back and are seeking to do business once more.

Much of our dismay in the whole flap had to do with money, but there was more. For the first time, patients and their doctors were identified as potential adversaries when they were used to being partners in confronting their common foes of injury and disease.

Here is what happened to me. Some two years before, I had operated for cancer upon a large, friendly man from a neighboring small town. When his cancer reappeared, there was nothing to offer him but the poison of chemotherapy. Mindful of all the hazards of such treatment and the advice to obtain informed consent, I had a document drawn up for such cases and presented one to him for his signature. He and his wife looked up at me in hurt surprise and he said, "Sure, Doc, I'll sign anything you say."

I was ashamed! The glow of that precious and sometimes fragile doctor-patient relationship was tarnished a little, and I was at fault. They trusted me, but I didn't quite trust them. The malpractice crisis had casualties other than impaired bank accounts.

ORGANIZED MEDICINE

Bear with me, if you will, for a few words about organized medicine. The question is asked these days whether there is any place for organized medicine in the future of health care. There is indeed. It is the only common ground on which all disciplines of medicine can meet and act in unison.

The course modern society follows is the sum

of the tensions and pressures exerted upon it. The stronger the support for organized medicine, the better the chance its voice will be heeded in the incessant din of society today. It will need all the strength it has to contend with the growing power of government. Only the AMA had the voice to challenge the Department of HEW in its faulty listing of physicians reported to have collected such large sums of money from Medicare in 1975. The list was 65% in error.



The AMA and the Hospital Association have joined forces to oppose the Carter Administration's plan to put a limit on increases in hospital charges. It seems likely this is a trial balloon. If it flies, then expect an attempt to control physicians' fees as well.

There is a so-called Consumer Protection bill before subcommittees in both Houses of Congress that is frightening in its implications. It would expand tremendously the powers of the Federal Trade Commission to permit its even greater

meddling in affairs of citizens. It has such power now that its threat of a suit against an organization often is enough to make the target surrender. Very few organizations have the resources to battle the Commission up through the courts. The government lawyers are there anyway and might as well keep busy.

Fortunately, the AMA has rebounded from its precarious position of a few years ago and its membership and strength are growing. Here at home there is a growing awareness among the physicians of Iowa that there must be a strong voice speaking for their patients and themselves. IMS membership is now already ahead of this time last year.

And now, you have been patient, but relief is at hand. There remains only to thank the officers, the committees, this House, and the members for all their efforts during the past year. For the privilege and honor of serving as your President, I thank you very much.


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HSA . . . SHPDA . . . SHCC – What's It All Mean?

HEALTH PLANNING may never become the nation's favorite pastime (as they say about baseball). But it's certainly a whole new ball-game (also as they say in baseball). Whether you regard it as having home-run or foul ball potential, health planning must be acknowledged as an enterprise of far-ranging significance.

Today's home base for health planning is the National Health Planning and Resources Development Act of 1974 (P.L. 93-641). The controversial nature of this law has been evident since its enactment on January 4, 1975. Even now it's being subjected to a court test.

But this discussion is meant to be informational—not a statement on the merits of the law or the emerging program. Suffice it to say, the Iowa Medical Society, while questioning a federalized program of this magnitude, has acknowledged it is the law of the land. The Society has urged its member physicians to be active in the program's evolution in Iowa, and to date the degree of professional participation has been good.

For the informed the following will be familiar and unnecessary. But for those Iowans—providers and recipients of health care—who know little about recent health planning developments, the new lexicon of acronyms is confusing. The following mini-glossary is provided for those in this latter category. These several entries have been taken from a longer listing prepared by the Iowa Health Systems Agency (that's HSA).

HSA (Health Systems Agency)—Established under the National Health Planning and Resources Development Act of 1974. Generally responsible for preparing and implementing plans designed to improve the health of the residents of its health services area; to increase the accessibility, acceptability, continuity and quality of health services in the area; to restrain increases in the cost of providing health resources. Three HSA's exist to serve portions of Iowa; the Iowa HSA

covers 90 of the state's 99 counties; the Iowa HSA is guided by a 30-member Board and has 5 sub-areas.

HSP (Health Systems Plan)—A detailed statement of goals; describing a healthful environment and health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable costs, for all residents of the area; which takes into account and is consistent with the national guidelines for health planning policy issued by the Secretary. . . .

SHPDA (State Health Planning and Development Agency)—A state agency to integrate health plans of the Health Systems Agency into a preliminary state health plan, to be submitted to a Statewide Health Coordinating Council for approval. It will assist the SHCC in the review of the state medical facilities plan required by the law and in the performance of its functions generally. It will serve as a designated planning agency in those states which participate in Section 1122 of the Social Security Act, and it will administer a state certificate of need program satisfactory to HEW.

SHCC (Statewide Health Coordinating Council)—To be composed of at least 16 members appointed by the Governor. Sixty percent of its members will be representatives of Health Systems Agencies, and at least one-half must be consumers. The Council will prepare the State Health Plan, review the budgets and applications for assistance of Health Systems Agencies, and advise the state for assistance of HSA's, and advise the state agency on the performance of its functions. It will also review any state plan or application submitted to HEW for receipt of funds under allotments made to states for health programs.

It's a complicated proposition. The preceding attests to that. How it works only time will tell!

IN THE PUBLIC INTEREST

Joining together is a natural pattern

When goals are common, joining together is natural. That's why the Iowa Medical Society is the best place for members to join together for their Professional Liability Insurance. The Iowa Medical Society is sponsoring a valuable program of malpractice coverage designed by Aetna Life & Casualty for your needs.

This program offers you the high limits of coverage demanded by today's medical realities. Yet your total insurance costs may be significantly reduced as a result of a special dividend plan developed by Aetna for the Society. This is possible in part, through a Program of Loss Control and Education. By helping you and your staff avoid malpractice pitfalls, the Program helps you control losses. And when it comes to service, you benefit from the personal attention of your local independent Aetna agent.

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OFFICIAL PROCEEDINGS

1977 HOUSE OF DELEGATES MAY 6-7, 1977 DES MOINES, IOWA

(Alphabetical Index—Page 298)

FRIDAY SESSION, MAY 6, 1977

The House of Delegates of the Iowa Medical Society was called to order by the Speaker, L. D. Caraway, M.D. of Amana, at 9 a.m., Friday, May 6. The House approved

the taking of attendance by signed registration cards. There were 114 delegates, 16 voting alternates and 14 ex-officio members present.

COUNTY	DELEGATE	COUNTY	DELEGATE	COUNTY	DELEGATE
Adams	C. L. Bain*	Jackson	J. A. Broman		D. C. Young
Appanoose	A. S. Owca	Jasper	T. E. Kiernan		M. E. Abrams*
Black Hawk	C. D. Ellyson	Johnson	K. J. Judiesch		R. F. Birge*
	D. M. Hansen		K. D. Dolan		C. H. Denser, Jr.*
	J. G. Napier		S. W. Greenwald		L. O. Ely*
Boone	A. M. Dolan*		D. E. Schnetzler		R. D. Eckoff*
Bremer	E. E. Linder		P. M. Seeborn		B. Carlota-Orduna*
Buchanan	G. J. Kimball		M. D. Sokoll		R. G. Smits*
Calhoun	P. J. Leehey		R. D. Whinery		D. L. Sweem*
Cerro Gordo	R. P. Ferguson		J. B. Wilcox	Pottawattamie-Mills	D. J. Walter*
	A. G. Chanco	Jones	A. P. Randolph		J. L. Knott
	W. G. Garrett	Kossuth	J. M. Rooney		E. B. Mathiasen
	R. E. McCoy	Linn	R. J. Barry		G. L. Neligh
	R. M. Powell		R. W. Conkling		M. E. Olsen
	W. C. Rosenfeld		A. C. Hass		A. M. Romano
	D. D. Van Etten		J. H. Lohnes		R. K. Fryzek
Cherokee	G. E. Michel		J. W. Reinertson	Poweshiek	H. R. Light
Chickasaw	J. C. Carr		W. J. Robson	Scott	A. W. Boone
Clay	J. X. Tamisiea		R. A. Sautter		J. C. Barker
Clinton	G. T. Schmunk		G. R. Wessel		W. B. Hofmann
Crawford	D. J. Soll	Mahaska	S. A. Smith		R. J. Ketelaar
Dallas-Guthrie	N. L. Krueger	Marion	J. E. Griffin		W. F. Ramsey
	E. E. Lister	Marshall	L. O. Goodman		P. L. Rohlf*
Davis	H. M. Perry		W. T. Shultz	Shelby	J. H. Spearing
Decatur-Ringgold	D. E. Mitchell		R. G. Boeke	Sioux	E. B. Grossmann, Jr.
Delaware	J. E. Tyrrell		J. L. Garred	Story	W. R. Bliss
Des Moines-Louisa	K. A. Hahn		D. N. Orelup		C. J. Chapple
	R. L. Kent		K. E. Wilcox	Tama	A. J. Havlik
	J. P. Stokovic		R. L. Zoutendam	Wapello	L. E. Coppoc
Dickinson	D. F. Rodawig, Jr.		W. E. Hicks		K. E. Lister*
Dubuque	J. S. Chapman	O'Brien	J. P. Trotzig	Washington	D. G. Sattler*
	K. K. Hazlet	Osceloa	J. M. Rhodes, Sr.	Wayne	K. A. Garber
	R. T. Melgaard	Plymouth	W. K. Downing	Webster	C. L. Dagle
	J. W. White	Pocahontas	Lester Beachy		D. J. Lulu
Emmet	H. A. Lindholm	Polk	R. T. Brown		M. E. Kraushaar*
Fremont	F. M. Ashler		J. L. Fatland	Woodbury	R. A. Boldus
Greene	E. D. Thompson*		Marshall Flapan		G. J. McGowan
Grundy	D. R. Kruschwitz		John Hess, Jr.		J. S. Pennepacker
Hamilton	G. A. Paschal		J. W. Hopkins		H. V. Robison
Hancock-Winnebag	L. R. Fuller		R. L. Kollmorgen		P. W. Wolpert
Harrison	T. C. Graham		D. O. Newland		D. M. Youngblade
Humboldt	J. W. Barnes		A. N. Smith		A. F. Benetti
Hardin	J. H. Coddington		M. E. Thoman		

*Alternate

LIAISON DELEGATES

C. W. Seibert

J. D. Ver Steeg

EX-OFFICIO MEMBERS OF THE HOUSE

J. F. Bishop

W. V. Wulfekuhler

L. W. Swanson

A. L. Sciortino

J. H. Kelley

L. D. Caraway

Hormoz Rassekh

Erling Larson, Jr.

J. R. Anderson

J. W. Eckstein

J. R. Scheibe

R. L. Wicks

V. L. Schlaser

J. H. Sunderbruch

W. R. Bliss, M.D., Secretary of the Society, moved the minutes of the May 2, 1976 session of the House of Delegates be approved as published in the July, 1976, issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Dr. Caraway introduced those individuals at the head table and welcomed new members of the House of Delegates. He reminded the delegates of their responsibility to their constituents not only at the House of Delegates meeting but throughout the year. He then explained the voting procedure of the House and introduced members of the Reference Committees. Dr. Bliss moved the reports of the HANDBOOK FOR THE HOUSE OF DELEGATES be approved as published.

Richard Palmer, M.D., president of the American Medical Association, was invited to address the House of Delegates. Dr. Palmer reviewed important developments in

health care nationally. In his remarks he noted (1) the high public ranking given the AMA in a recent Gallup Poll; (2) the good opportunity physicians have to share their political views with patients; (3) the improvement in professional liability with some 400 tort law changes having been enacted in 40 states; (4) the danger inherent in the Health Planning & Resources Development Act of 1974, which threatens to bring with it rate setting and public utility medicine; (5) the continued insistence by government that fraud and abuse are rampant in the Medicare and Medicaid programs; (6) the action of the Federal Trade Commission to attempt to disrupt long-established ethical principles relating to the solicitation of patients and advertising; (7) the FTC's additional charges that the profession controls the medical school accreditation process and therefore controls the output of medical manpower; (8) the inaccuracies of HEW in its release of the names of physicians who received more than \$100,000 in Medicare payments in 1975; (9) the successful efforts of the AMA in gaining judicial review of UR and other federal regulations; and (10) the efforts of the AMA to be involved positively in the consideration of national health insurance. Dr. Palmer described AMA responses to various of the preceding issues and indicated his belief that the Association is in a position of strength at this time.

Reports of Officers

FROM THE OFFICE OF THE SECRETARY

The Secretary of the Iowa Medical Society is responsible for maintaining membership and dues records; conducting the official correspondence, notifying members of meetings, officers of their election, and committee members of their appointments and duties; and preparing minutes of all official meetings. Assistance is also provided to the district councilors in organizing and improving the component societies, and in extending the usefulness of the IMS.

HOUSE OF DELEGATES

Proceedings of the 1976 Annual Meeting of the House of Delegates were published in the July 1976 issue of the IMS JOURNAL. The necessary administrative procedures have occurred to implement the directives of the delegates.

District councilors have received assistance from IMS staff in organizing their caucuses in preparation for the 1977 Annual Meeting and in preparing for the March 27 meeting of the Nominating Committee.

ANNUAL SCIENTIFIC PROGRAM

Telemark Lodge in Cable, Wisconsin, is the site for the 1977 Annual Scientific Session. The program will be presented July 12-14 in three full-morning sessions. This will be the third time since 1973 the scientific program has been scheduled outside the State of Iowa. This provides

opportunity for physicians and their families to have a continuing medical education experience and also enjoy outstanding recreational facilities.

EXECUTIVE COUNCIL AND JUDICIAL COUNCIL

To conserve costs incurred by the Judicial and Executive Councils, as well as the time of the members, arrangements have been made this past year to schedule meetings of the Board of Trustees and Judicial Council in the morning, followed by a session of the Executive Council in the afternoon. Thus, the need for physicians spending a day and a half in Des Moines has been eliminated.

Three meetings of the Executive Council have been held since the final session of the House of Delegates in 1976, and a fourth is scheduled on April 13. The Council is the interim policy-making body which meets between sessions of the House.

The Judicial Council also met three times the past year, and a fourth session is scheduled April 13. The principal responsibilities of the Judicial Council are (1) to approve applications for IMS membership; (2) to consider questions on membership and ethics; and (3) if necessary, to discipline members of the Society.

A report from the Judicial Council appears elsewhere in the HANDBOOK.

BOARD OF TRUSTEES

Regular meetings of the Board of Trustees are held monthly and special meetings are called as necessary. The Board is responsible for conducting the business of the Society, and there is almost daily communication between IMS staff members and the President, Chairman of the Board, and other IMS officers.

COMMITTEES

There are 19 standing and 23 special committees of the IMS. Over 25 official meetings have been held since the House of Delegates adjourned its final session last May. Additional committee meetings are scheduled prior to the opening session of the 1977 House of Delegates.

In addition to formal committee work, staff members maintain regular contact with committee chairmen and members by telephone and personal visitation to carry out specific projects and activities.

The Society is represented on councils and committees of various state and voluntary agencies, e.g., the Iowa Health Systems Agency, State Health Coordinating Council, Advisory Committee on Emergency Medical Services, Iowa Health Council, Advisory Council on Family Practice Residencies, State Drug Abuse Advisory Council, Advisory Committee for Family Nurse Practitioners, etc.

NATIONAL, REGIONAL AND STATE CONFERENCES

The IMS is represented at important state, regional, and national conferences because the Trustees believe gathering and exchanging information on medical programs and issues are important and beneficial to the Society. However, an effort is made to be selective in authorizing IMS representation at such programs. During the past two years the number of meetings attended by IMS representatives has been reduced significantly. The Society was represented at national conferences on medical education and continuing medical education, legislation, political action, professional liability, negotiations, etc.

IOWA REPRESENTATION AT THE NATIONAL LEVEL

Close liaison between the IMS and AMA is maintained at both the officer and staff level. Several IMS members serve on AMA councils and committees, including the following: Clarence Denser, Jr., M.D., Des Moines, Committee on Quackery; Jack Moyers, M.D., Iowa City, Residency Review Committee-Anesthesiology; B. F. McCabe, M.D., Iowa City, Residency Review Committee-Otolaryngology; George Penick, M.D., Iowa City, Archives of Pathology; Craig Ellyson, M.D., Waterloo, Joint Commission on Health Problems in Education of NEA and AMA; Roger Simpson, M.D., Iowa City, Interspecialty Council (American Academy of Otolaryngology); Maurice Van Allen, M.D., Iowa City, Interspecialty Council (American Academy of Neurology); Scientific Section Council Officers—Paul Seeborn, M.D., Iowa City (American Academy of Allergy); Carl Graf, M.D., Iowa City (American Association of Neurological Surgeons); David Culp, M.D., Iowa City (American Urological Association); George Bedell, M.D., Iowa City (American Thoracic Society).

STAFF

As Executive Vice President, Eldon E. Huston serves as chief administrator for the IMS, heads a staff of 12 full-time and 2 part-time individuals, and maintains close contact with officials of the Society. He also has established close liaison with the provider services division of Blue Cross-Blue Shield, which includes both hospital and physician

relations. This division has six physician relations representatives who, with direction from the IMS, maintain personal contact with physicians throughout the state and provide a valuable service to them, as well as to organized medicine and Blue Cross-Blue Shield. The field representatives operate in designated regions and, according to comments from physicians, function effectively and provide valuable information and assistance.

COMMUNICATIONS

In its continuing efforts to enhance communications with the membership, the IMS has developed a regular monthly publication entitled "IMS UPDATE" which is mailed to all members of the IMS. It contains important information concerning the various issues confronting the medical society, as well as pertinent activities of IMS officers and committees. In addition to the UPDATE, special Legislative Bulletins and News Bulletins are distributed to IMS members. The following communications are also published and/or distributed through the IMS:

1. **IMS JOURNAL**—to all members; subscribers; clinical departments at the University of Iowa College of Medicine as a reference for residents, interns and medical students; also, exchange copies with other medical journals.

2. **IN THE PUBLIC INTEREST**—reprints of this section of the IMS JOURNAL are mailed monthly to all members of the Iowa Press and Iowa Daily Press Association, all members of the Iowa General Assembly, and members of the IMS Auxiliary.

3. **IMS AUXILIARY NEWS**—to all members of the IMS Auxiliary.

4. **AMERICAN MEDICAL NEWS**—to all members of the Iowa General Assembly.

5. **AMA EXECUTIVE VICE PRESIDENT'S LETTER**—to all members of the Executive Council.

IMS MEMBERSHIP

Iowa Medical Society membership for 1976 totaled 2,396. Of this number, 155 held active dues-exempt membership (88 life members, 63 residents, and 4 members in military service), and 132 associate members were exempt from the payment of dues. There were 48 counties (in 46 single or two-county societies) in which 100 per cent of the county society members held membership in the IMS. There were 331 eligible non-members in Iowa. The percentage of eligible physicians who held IMS memberships was 88 for the year.

COUNTY SOCIETIES HAVING 100 PER CENT MEMBERSHIP
IN IMS IN 1976

Adair	Fremont	Mahaska
Adams	Greene	Monona
Appanoose	Grundy	Montgomery
Audubon	Hamilton	O'Brien
Boone	Hancock-Winnebago	Plymouth
Butler	Hardin	Pocahontas
Cedar	Harrison	Shelby
Chickasaw	Humboldt	Tama
Clay	Ida	Union-Taylor
Clayton	Jasper	Van Buren
Crawford	Jefferson	Washington
Davis	Jones	Wayne
Delaware	Keokuk	Worth
Dickinson	Kossuth	Wright
Emmet	Lucas	
Franklin	Lyon	

1976 IMS MEMBERSHIP RECORD

Component Society	Active Members	Life Members	Associate Members	Eligible Non-Members	Percentage	Component Society	Active Members	Life Members	Associate Members	Eligible Non-Members	Percentage
Adair	1	..	..	..	100	Jasper	16	1	1	..	100
Adams	2	..	..	..	100	Jefferson	8	1	..	..	100
Allamakee	6	1	..	1	88	Johnson	270	..	5	68	79
Appanoose	5	1	2	..	100	Jones	7	..	..	..	100
Audubon	2	..	..	..	100	Keokuk	4	..	..	..	100
Benton	7	..	..	4	64	Kossuth	7	..	..	..	100
Black Hawk	128	4	8	4	97	Lee	31	3	1	..	95
Boone	16	..	3	..	100	Linn	150	5	11	21	89
Bremer	9	1	1	1	92	Lucas	2	1	..	..	100
Buchanan	9	..	..	6	60	Lyon	4	..	..	..	100
Buena Vista	8	1	1	3	77	Madison	3	..	..	1	75
Butler	4	..	1	..	100	Mahaska	13	3	..	..	100
Calhoun	9	..	..	1	90	Marion	9	1	..	5	67
Carroll	13	4	3	4	83	Marshall	44	1	..	1	98
Cass	10	..	..	3	77	Mitchell	8	..	1	1	90
Cedar	4	..	..	..	100	Monona	6	..	..	..	100
Cerro Gordo	83	3	6	4	96	Monroe	3	..	..	1	75
Cherokee	17	2	1	5	80	Montgomery	10	2	..	..	100
Chickasaw	6	..	2	..	100	Muscatine	16	1	2	2	90
Clarke	2	1	..	1	75	O'Brien	9	1	..	..	100
Clay	14	..	..	..	100	Osceola	1	..	..	3	25
Clayton	8	..	1	..	100	Page	17	1	..	2	90
Clinton	28	..	3	14	69	Palo Alto	3	1	..	3	57
Crawford	9	..	..	..	100	Plymouth	9	..	1	..	100
Dallas-Guthrie	14	1	2	6	74	Pocahontas	5	1	..	..	100
Davis	16	..	4	..	100	Polk	343	18	13	63	86
Decatur-Ringgold	5	..	1	2	75	Pottawattamie-Mills	71	1	4	4	95
Delaware	7	..	..	..	100	Poweshiek	10	..	..	4	71
Des Moines-Louisa	36	3	3	7	86	Sac	..	..	1	5	17
Dickinson	5	..	1	..	100	Scott	102	8	3	11	91
Dubuque	55	1	2	32	64	Shelby	6	..	..	..	100
Emmet	10	..	..	..	100	Sioux	14	..	2	2	89
Fayette	10	..	..	4	71	Story	61	1	8	6	92
Floyd	8	2	2	3	80	Tama	5	..	..	..	100
Franklin	1	..	1	..	100	Union-Taylor	13	..	..	..	100
Fremont	4	..	..	..	100	Van Buren	2	..	..	..	100
Greene	8	..	..	..	100	Wapello	29	..	4	1	97
Grundy	7	..	..	..	100	Warren amalgamated with Polk	..	..	..	..	..
Hamilton	6	..	2	..	100	Washington	8	..	..	..	100
Hancock-Winnebago	8	..	..	..	100	Wayne	1	..	..	..	100
Hardin	10	..	3	..	100	Webster	38	1	3	5	89
Harrison	6	..	2	..	100	Winneshek	11	1	1	1	93
Henry	8	..	2	6	63	Woodbury	119	6	4	1	99
Howard	5	..	1	1	86	Worth	3	..	..	..	100
Humboldt	4	..	3	..	100	Wright	11	2	..	..	100
Ida	1	..	..	..	100	Student IMS	27	..	..	..	..
Iowa	4	1	..	3	63						
Jackson	9	1	..	3	77						
						TOTALS	2,176	88	132	331	88

REPORT OF THE TREASURER

The following financial statement reflects the fiscal status of the Iowa Medical Society as of December 31, 1976.

The 1976 income exceeded expenses by \$27,612.21.

ASSETS

Current Assets:

IMS Checking Accounts	\$ 9,104.29
IMS Savings Account	41,071.09
Pension and Disability Insurance	
Due from Employees	308.98
Investments	135,061.20
Short-term Investments	35,000.00
Accounts Receivable	62,500.00
TOTAL CURRENT ASSETS	\$283,045.56

Fixed Assets:

Land	\$ 74,216.96
Building	\$308,264.76
Office Furniture & Equipment	59,484.57

Less: Reserve for Depreciation 306,165.00 \$ 61,584.33

Net Fixed Assets \$135,801.29

TOTAL ASSETS \$418,846.85

LIABILITIES AND NET WORTH

Liabilities:

Accounts Payable	\$ 2,351.74
Accrued Personal & Property Tax	14,000.00
Use Tax	137.47
Deferred Income	25,000.00
Deferred Compensation	135,061.20
Due to Employees	9,996.07
TOTAL LIABILITIES	\$186,546.48

Net Worth:

Balance 1-1-76	\$204,688.16
Add: Net Excess of Income over Expenses 12-31-76	27,612.21
Balance Net Worth	\$232,300.37
TOTAL LIABILITIES AND NET WORTH	\$418,846.85

IOWA MEDICAL SOCIETY
STATEMENT OF INCOME AND EXPENSES
For the Year Ended December 31, 1976

Income for the Year 1976:

Dues—State Society	\$404,768.33
Interest and Dividends on Investments ...	15,902.60
Miscellaneous	1,590.18
AMA Collection Commissions	4,305.85
Gain on Sale of Stock	1,296.50
TOTAL INCOME	\$427,863.46

Expenses for the Year 1976:

Annual Scientific Meeting (Net)	\$ (400.20)
Council Expense	2,608.12
County Society Services	7,597.43
Depreciation, Building & Equipment	24,000.00
Dues and Subscriptions	2,570.00
Employee Pension, Disability & Health Programs	23,968.27
Field Service	10,371.07
General Administrative Expense	3,210.92
House of Delegates	5,015.18
Insurance	3,707.49
Journal (Net)	25,026.59
Legal Expense	4,275.26
Lights, Gas & Water	8,298.63
Office Stationery & Supplies	8,736.61
Postage	11,400.98
Repairs & Maintenance	12,545.71
Salaries (Net)	142,209.22
Service Contracts—Machines	1,438.34
Taxes:	
Personal & Property	11,654.25
Social Security & Unemployment	8,815.64
Telephone & Telegraph	8,552.07
Travel—Officers	18,366.39
Travel—Salaried Employees	13,882.21
Trustee Expense	3,537.91
IMS Auxiliary	9,836.38
Committee Expense	29,026.78
TOTAL EXPENSE	\$400,251.25
Net Excess of Income over Expenses for 1976	\$ 27,612.21
THOMAS A. BURCHAM, M.D., <i>Treasurer</i>	

BOARD OF TRUSTEES

The Board of Trustees will submit an up-to-date summary concerning Society finances and programs at the opening session of the 1977 House of Delegates. The Board has responsibility for conducting the business affairs of the IMS, and also oversees implementation of the various projects and activities of the Society, which are carried out under policies set by the House of Delegates.

The Board meets in regular session each month, and there is almost daily contact between IMS staff members and appropriate officers.

A. J. HAVLIK, M.D., *Chairman*

REPORT OF THE JUDICIAL COUNCIL

The Judicial Council of the Iowa Medical Society has met three times in 1976-77. A fourth meeting is scheduled prior to the annual session of the House of Delegates. Membership responsibilities assigned to the Council in the Articles of Incorporation and By-Laws have received careful attention.

The 12 councilors function independently in their respective districts as peacemakers and interpreters of

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ethics. The Council believes that maximum effort should be exerted at the local or district level to resolve questions or concerns.

Following in summary form are some topics considered by the Council this year:

Dues Interpretation—The question has been raised as to whether service in the United States Public Health Service or the National Health Service Corps equates with military duty. Dues are waived for those in the military. The decision was reached not to regard those in the first two categories as dues exempt.

Advertising and Solicitation by Physicians—The Council has followed developments occurring elsewhere in the country with respect to governmental action against medical and other professional bodies in the areas of antitrust, advertising, use of relative value schedules, etc. These developments are of considerable importance to physicians. In 1976 the AMA Judicial Council issued an updated statement on advertising and solicitation. This statement was presented in summary form as an "In the Public Interest" feature in the IMS JOURNAL.

Unified Membership—To assist in fulfilling the 1976 House of Delegates' directive that by-law language be prepared to require unified membership, the Council has obtained reference information from states where unified membership provisions exist. It has been noted that while six or seven states require unified membership the recent trend has been away from the concept. Further, there is doubt as to the benefit it might have in Iowa.

Intraprofessional Communications—The Council has again had occasion to consider the distribution of form letters by physicians to colleagues. Included here are certain holiday greetings, letters regarding the acquisition of new equipment or the performance of new procedures,

etc. Use of this mechanism, however well intended, is questioned by the Council.

Impaired Physicians—The Council has discussed the important need to have available qualified physicians to review and assist those of their peers who may have a physical or mental impairment. The Council is aware of Society communication with the Board of Medical Examiners on this subject. The services of the Society have been offered to the Board to provide expertise or counsel. One such evaluation has been made by the IMS Committee on Psychiatric Care.

Patient Abandonment—The subject of patient abandonment has been before the Council. The consideration was prompted by a newspaper story which described a situation wherein a Medicaid recipient was declined service after having been given an appointment and after having reached the physician's office. The subject is complex. The Council has secured a three-part printed discussion on patient abandonment from the AMA for future reference use.

Telephonic Payment Authorization for Professional Services—This matter is associated with a new service provided by a savings and loan firm. The firm pays bills

authorized by account-holders utilizing telephonic procedures. The question is whether it is ethical for the name of a clinic or individual physician to be listed in any directory provided to customers of the savings and loan. The Council has determined such a listing is not unethical so long as it is used for informational purposes and not for promotional use by the institution.

There have been several additional ethical questions before the Council during the year, submitted by individual physicians, county societies, etc. The Council has sought to give appropriate consideration to each of these matters.

The 1977 district caucuses are being held as this report is prepared. This is an annual effort for which the councilors assume responsibility. The caucuses are held to consider matters relating to the election of officers. They also afford an opportunity for the exchange of information between the councilors, the delegates and other interested physicians. The councilors individually, and the Council collectively, are anxious to foster active participation in the Society and high professionalism by its member physicians.

J. E. TYRRELL, M.D., *Chairman*

Reports of Standing Committees

COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

The Committee on Articles of Incorporation and By-Laws has not met during the past year and has no specific matters to report.

The 1976 House of Delegates asked the Committee to draft appropriate amendments to the Articles and Bylaws which would require "unified membership" for Iowa physicians, and to submit the language to the House of Delegates in 1977 for consideration and action.

Such a membership provision would require that a physician joining a county medical society also join the Iowa Medical Society and American Medical Association.

This matter is still under study and a Supplemental Report will be presented to the 1977 House of Delegates.

K. J. JUDIESCH, M.D., *Chairman*

REPORT OF THE GRIEVANCE COMMITTEE

The Grievance Committee disposed of eight cases during the past year. Three have not yet been completed. No remarkable problems occurred during this past year. The number of cases referred to the Committee have continued at a low level.

S. E. ZIFFREN, M.D., *Chairman*

COMMITTEE ON HEALTH EDUCATION

The Committee on Health Education continues to respond to numerous requests for educational pamphlets and films on various health subjects. The Society also secures physicians to speak at both professional and lay group meetings, on request.

Although the regular radio health series has been discontinued at WOI Radio/Ames, the Committee does cooperate with both WOI Radio and Television in suggesting subjects and speakers for various discussion pro-

grams. This past year the Society arranged a panel discussion on health planning for the Dimension 5 evening television program, and a special panel presentation on the use of physician's assistants and family nurse practitioners on a daytime television show. Speakers for several radio programs were also contacted.

At the request of the IMS Board of Trustees, the Committee will investigate the feasibility of providing Iowa newspapers with regular news releases containing health information for the lay public. Such releases would supplement the "In the Public Interest" articles from the IMS JOURNAL, which are now being mailed to state news outlets.

The Iowa Medical Society provided administrative consultation and assistance to a professor who is completing a doctoral study at the University of Northern Iowa. The study was to identify attitudes and perceptions of Iowa physicians toward medical care services which are provided to Iowa citizens. A questionnaire was mailed to all IMS members approximately one year ago, and the results of the study will be provided to the IMS at some convenient date.

Your Committee Chairman has served for several years as a member of the Joint Committee of the AMA and National Education Association on Health Problems in Education. Through this Council, physicians and educators consider various subjects related to the health of children and youth. Many recommendations emanating from the Joint Committee have been valuable in the development of school health programs.

Although the Committee has not met for sometime, it functions on a stand-by basis, and is ready to assist county medical societies and individual physicians with special health education programs for use in the schools or mass communications media.

C. D. ELLYSON, M.D., *Chairman*

NECROLOGY LIST

The following members of the Iowa Medical Society died during 1976:

	Age
Oscar H. Banton, Charles City	90
Charles E. Block, Davenport	86
George Braunlich, Davenport	86
William F. Brinkman, Pocahontas	90
Clarence E. Broderick, Cherokee	82
Robert G. Carney, Iowa City	62
Albert B. Carstensen, Indianapolis, Indiana	86
George W. Egermayer, Elliott	88
Norman C. Flater, Floyd	74
Francis A. Gillett, Oskaloosa	90
Paul L. Gjerstad, Maquoketa	36
Dennis H. Kelly, Des Moines	78
Ernest G. Kieck, Horseshoe, North Carolina	81
Charles W. Latchem, Des Moines	62
Frank B. Leffert, Centerville	83
Dean M. Lierle, Iowa City	81
Charles T. Maxwell, Sioux City	87
William B. McTaggart, Fort Dodge	73
Robert E. Murphy, Burlington	52
Carson W. Palmer, Guttenberg	94
Frank J. Piekenbrock, Dubuque	80
Christian E. Radcliffe, Iowa City	59
Jesse L. Saar, Laguna Hills, California	85
George C. Scanlan, DeWitt	75
Herman J. Smith, Des Moines	70
Kuei shu Sun, Ames	65
John B. Thielen, Fonda	67
Bernard L. Trey, Marshalltown	84
Richard L. Waste, Manchester	46
Edgar B. Wilcox, Oskaloosa	98

COMMITTEE ON LEGISLATION

The 66th Iowa General Assembly, the longest in Iowa's history, adjourned May 29, 1976. Although the IMS experienced major victories in the previous year, 1976 was a frustrating year. The second half of the session was not without victories, but success was achieved often by prevention of bad rather than passage of good legislation.

As in 1975, a major effort last year was directed toward further reform in the critical medical liability area. During the '75-'76 recess, a joint legislative interim committee studied the medical liability problem. The IMS participated actively in the interim deliberations. Senate File 1310 was the product of the interim study and it contained the following: assurance of quality care; periodic payments; limit on noneconomic loss.

Many manhours were invested by IMS Legislative Contact Physicians and other physicians in the liability legislation. Their efforts almost paid off. The critical vote came after Senate debate on an amendment to the bill limiting recovery on non-economic loss to \$200,000. The amendment lost by a vote of 24 to 25. Once voted upon, the Senate proceeded to strip the bill of several measures of value and then passed the stripped down version.

An attempt was made in the House of Representatives to restore the bill but time ran out.

An IMS priority bill successfully passed both chambers and was signed into law. This new law provides for identification of organ donors by a decal affixed to the driver's license.

One of the less dramatic IMS victories came with the passage of House File 200, a bill relating to the labeling of prescription drugs and bio-equivalency of drugs. The passage of the bill changed Iowa law and permits generi-

cally equivalent drugs to be substituted by the pharmacist providing that: (1) the physician fails to specify no substitution is permitted; (2) the patient or his agent fails to request no substitution be made; and (3) the drug which might be substituted does not appear on the list of non-equivalent drugs provided by the State Department of Health. The IMS was successful in striking certain objectionable language from the bill which would have permitted the pharmacist to make therapeutic judgments. Another provision also deleted from the bill would have required the physician to indicate on the prescription form, in his own handwriting, that no substitution be permitted.

House File 1281 created an "Interagency Coordinating Council on Radiation Safety." Donald C. Young, M.D., chairman of the Committee on Legislation, is a member of this Council. IMS participation has been beneficial in developing reasonable radiation safety legislation for 1977.

Officials of the IMS met with nursing representatives to discuss their 1976 legislation. The IMS was particularly interested in making certain that any legislation did not encroach upon the traditional role of the physician and nurse in the delivery of health care. A bill relating to the practice of nursing and providing for disciplinary procedures was passed.

The IMS opposed several pieces of legislation which failed to receive floor debate. Among the proposed bills that died in committee were:

1. Ownership of records; a bill which would make patients' records the property of the patient or his appointed representative.
2. Patients' rights; legislation which would declare fair treatment, privacy, consideration, etc. The IMS believes these things should exist without having to be legislated.
3. Regulation of blood; a bill placing undue restrictions on the use of purchased blood.
4. Employment of radiologists and pathologists by hospitals; would have removed the restrictions against employment for a profit of radiologists and pathologists by hospitals.

The IMS Committee on Legislation has three classifications: (1) items to receive positive action, (2) items requiring IMS input, and (3) items for possible defensive action.

Items for positive action:

Medical liability including—(a) Assurance of quality care; (b) Periodic payments of awards; (c) Breakdown of verdicts into past and future damages; (d) Limitation on awards of \$100,000; (e) Permit voluntary, binding arbitration of prospective disputes; (f) Establish concept of "proof beyond a reasonable doubt."

Adequate appropriations for: (a) The Family Practice Residency program, and (b) The Medicaid program.

Radiation safety legislation.

Items requiring IMS input:

Certificate of need, and Compulsory immunization.

Items for possible defensive action:

Revision of the corporate practice rule; Use of diagnostic drugs by optometrists; Patients' rights; Ownership of records; Control of blood; and Expansion of chiropractic.

As this report is written, the 1977 General Assembly is in its 28th day. The IMS and the Committee on Legislation are monitoring approximately 25 bills. These include:

House File 179—Malpractice by the Committee on Commerce. The bill re-introduces the measures originally contained in Senate File 1310 which lost in 1976.

Autopsies—Two bills mandate release of autopsy reports.

Patients' Rights—This is the 1976 bill which seeks to legislate privacy, fair treatment, etc.

Radiology-Pathology—The bill would reverse Iowa's corporate practice rule and permit employment of radiologists and pathologists.

Use of medical procedures to prolong life—The bill would allow a person to execute a document which would deny the use of medical, surgical or other procedures to prolong life in certain circumstances.

Compulsory Immunization—This proposed legislation would require immunization of persons against diphtheria, pertussis, rubella, tetanus and poliomyelitis before entering any elementary or secondary school.

It should be emphasized that legislation before the General Assembly is monitored by the Committee. A posture of flexibility is necessary to react to unexpected legislation or amendments that may change the intent of any bill. The Committee on Legislation works closely with IMS Legislative Contact Physicians and any success is the result of a team effort.

DONALD C. YOUNG, M.D., *Chairman*

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

In accordance with an action of the 1975 House of Delegates, the IMS, through its Committee on Medical Education and Hospitals, has been approved by the American Medical Association to survey Iowa institutions and agencies which conduct continuing medical education programs for physicians. IMS recommendations are submitted to the AMA Council on Medical Education which grants CME accreditation to approved institutions and organizations. Once an institution is accredited, any CME program may be given Category I/Physician's Recognition Award designation by the director of medical education if it meets the program "Essentials" as outlined by the AMA.

On July 27, 1976, the IMS was advised that its CME Accreditation Program had been granted full approval by the AMA for a period of four years.

To date one Iowa hospital (Mercy Hospital/Des Moines) has been accredited by the IMS and AMA for its continuing medical education activities; one other hospital and one voluntary health agency have been recommended for accreditation; and one on-site visit is pending subject to a review and approval of a pre-survey questionnaire submitted by a regional blood bank in the state.

Information regarding the accreditation program has been provided to county medical society presidents and secretaries, chiefs of all hospital medical staffs, and other organizations and institutions in the state.

The following recommendation of the IMS Medico-Legal Committee was referred to the Committee on Medical Education and Hospitals for comment: "That the IMS support a requirement that physicians complete a specified number of hours of continuing medical education; this requirement should either be legislative and associated with licensure, or as a provision of membership in order to be in good standing in the IMS."

In considering this matter, the Committee approved a motion that the IMS reaffirm its support for legislation to require all professional and occupational licensees to participate in continuing education as a condition of license renewal, with authority granted to the Board of Medical Examiners (and other appropriate boards) to establish CME requirements by rule and regulation. The Committee expressed the opinion that it is premature to address the question of establishing a CME requirement for member-

ship in the IMS since enactment of legislation requiring CME for the re-registration of a license would nullify a need for such a membership requirement. However, the Committee members did agree, if an appropriate bill is not passed by the Iowa Legislature, the matter of linking a CME requirement with membership in the IMS should be reconsidered. The comments and recommendations of the Committee were submitted to and approved by the Executive Council in January 1977.

The Committee has conferred with representatives of the Board of Medical Examiners regarding possible CME requirements, and further discussions will undoubtedly occur if legislation is enacted.

Representatives of the Committee attended the Fifth Biennial Conference on Medical Education in Chicago last fall, and participated in various workshop sessions concerned with CME accreditation programs and activities.

The Committee is pleased to note that the IMS and Iowa Hospital Association will sponsor a special "Joint Conference" for physicians, hospital administrators, and hospital trustees on March 12. This is an appropriate follow-up to the distribution last year of an AMA booklet titled "Physician-Hospital Relations/1974," along with the summary of a brief prepared on this subject by the Society's legal counsel. These materials were mailed to the chiefs of all hospital medical staffs in the state, and have been provided on request to other interested individuals. The joint conference scheduled in March will focus attention on health care costs, assuring medical care quality and competency, and other issues of concern to the medical profession and hospital officials.

The Committee wishes to call attention to the IMS Scientific Program to be held July 12-14 at Telemark Lodge in Cable, Wisconsin. An excellent series of scientific presentations has been arranged. The program is approved for Category I Credit/AMA Physician's Recognition Award, and credit is also being sought from the American Academy of Family Physicians.

CARL R. ASCHOFF, M.D., *Chairman*

COMMITTEE ON MEDICAL SERVICE

The Committee on Medical Service met on June 9, 1976.

Multiphasic health testing programs in Iowa were reviewed. After a discussion of the legal status of such programs, the committee agreed the Iowa Medical Society should cooperate with multiphasic health testing programs in Iowa only after such programs have demonstrated (1) reliability of service and quality control; (2) medical direction by an Iowa licensed physician; and (3) a willingness to seek approval by the local county medical society before operation in the area.

The Committee discussed all aspects of surgical treatment for morbid obesity. A subcommittee, chaired by H. F. Trafton, M.D., was appointed to review all materials and to report to the standing committee prior to the July 29, 1976 meeting of the IMS Executive Council.

The Subcommittee on Surgical Treatment of Morbid Obesity reviewed pertinent material and made its recommendations to the standing committee.

The Committee on Medical Service presented its findings to the IMS Executive Council. The following motions were approved by the Council:

1. The Iowa Medical Society withdraw any formal approval of guidelines for surgical treatment of morbid obesity, recognizing this as an appropriate function for the Iowa Foundation for Medical Care.

2. Proposed "guidelines" drafted by a special committee on July 14, 1976, be forwarded to the Iowa Foundation for Medical Care for "consideration and action."

The 1976 IMS House of Delegates directed the Committee on Medical Service to study a resolution calling for payment by Blue Cross/Blue Shield of office overhead charges (surgical trays, etc.). A subcommittee chaired by T. D. Throckmorton, M.D., will meet in early March to discuss the subject.

R. S. GERARD, M.D., *Chairman*

SUBCOMMITTEE ON MEDICAL PRACTICE IN HEALTH FACILITIES AND HOMES

Several regional public hearings were held during the fall of 1976. These meetings covered a wide range of social and economic problems and included health care which is provided in homes and health facilities.

Witnesses agreed some of the greatest needs were:

1. Expanded benefits for home health/homemaker services by third party payors.
2. Improved transportation to medical and social facilities.
3. Services (health and others) provided based on need rather than income or ability to pay.
4. Elimination of the artificial distinction between health and social services.
5. Development of a more coherent federal policy with regard to home health care requirements and eligibility in Title XVII (Medicare), Title XIX (Medicaid) and Title XX (Social Services).
6. Improve coordination of delivery of services between existing health services (physicians, visiting nurses, hospitals, intermediate care facilities, custodial homes, home health agencies, etc.).

The Iowa phase of the national swine flu (A/New Jersey) immunization program was coordinated by the State Department of Health with advisory support provided by an ad hoc committee of the IMS. Approximately 55 per cent of the Iowa population was immunized before the program was halted December 16, 1976.

J. F. VEVERKA, M.D., *Chairman*

MEDICO-LEGAL COMMITTEE

The Medico-Legal Committee continues to pursue its active involvement in the professional liability area. And we are pleased to be able to report positive developments to the 1977 House of Delegates. It should be noted that several resolutions approved by the 1976 House of Delegates have served to guide the Committee this year.

Undoubtedly, the most significant development this year has come as a response to the following resolution approved by the 1976 House of Delegates:

Resolved, That the Society maintain its active liaison with the insurance industry and pursue with any reputable company the possibility of a Society-sponsored group type coverage, with any such program to be presented for approval either to the Executive Council or the House of Delegates.

Pursuant to this, on January 27, 1977, the Medico-Legal Committee submitted the following recommendation to the IMS Executive Council:

That the Iowa Medical Society enter into an agreement with the Aetna Life and Casualty to offer to member physicians the opportunity to obtain their liability insurance coverage through a program sponsored by the Society and offered by Aetna, with the authorization given to the Medico-Legal Committee, acting with endorsement from the Board of Trustees, to finalize the details of the program and proceed toward its full implementation.

This recommendation was accepted by the Executive Council and the program is scheduled to become officially operative on March 15, 1977. The recommendation of the

Committee was submitted following extensive study of the proposal. Informational material on the program has been prepared for a mailing to all member physicians. In addition, a series of briefings at county medical society meetings is in process.

Full details of the sponsored program will not be presented in this report. However, several main features of the program are (1) occurrence form of coverage, (2) competitive premiums, (3) guaranteed coverage (initially for three years), (4) direct and extensive involvement by the Society in claims review, underwriting appeals, rate determination, loss control and education, etc., (5) availability of excess or umbrella coverage, (6) marketing through local agents, and (7) a cost-plus approach with dividend potential.

The Iowa Medical Society becomes the ninth state medical association to affiliate with the Aetna. We can report that an excellent relationship has developed in the early phase of the program with the Aetna representatives in Iowa. Mr. Robert Reiber, the Iowa manager for Aetna, has been fully cooperative. He has been supported in this regard by Mr. Bill Everett, who has marketing responsibilities in Iowa. In recent days, Mr. Roger Detrich has been named the account coordinator, and it will be with him that much of our liaison will occur.

It should be stressed this is a voluntary program for interested physician members of the Iowa Medical Society. Its success will depend on adequate numerical participation. Therefore, the Committee urges all physicians to examine the program carefully and weigh the merits of enrolling.

The following brief comments are in response to other professional liability actions taken by the 1976 House of Delegates:

Public Information: The House requested attention be given to further efforts to make the public aware of the professional liability situation. While this activity has not been highly formal, the Society has distributed periodic news releases, has prepared in the Public Interest features in the IMS JOURNAL, and has used other means to increase public awareness of the problem. The announcement of the new Aetna program has resulted in favorable publicity regarding the efforts of the profession to stabilize and improve the professional liability situation.

Counter Litigation: The House requested evaluation of this mechanism as a means of thwarting non-meritorious court action against physicians. The Committee conducted a fall survey of state associations to determine the degree of activity going on in this area. More extensive contact has been pursued with the AMA and the Illinois State Medical Society. In line with the request of the House, these efforts were reported to the Executive Council. An informational mailing was sent to Iowa physicians with background material about countersuits. The Committee is able to report that two Iowa physicians are pursuing legal action in this area at the present time. The Society has contacted these two physicians and their legal counsel to offer its informational resources.

Disclosure of Claims Information: The House referred to the Committee a resolution calling for full disclosure of information by the insurance industry. The adoption of the Aetna program represents a step forward here in that it will allow the Society to be privy to data which relates to program participants. In addition, the Committee has obtained the quarterly reports from the study of the National Association of Insurance Commissioners. This study involves a comprehensive analysis of those claims closed in a 12-month period in 1975 and 1976. It is fair to say that information is developing in the professional liability area which was nonexistent two or three years ago.

State Legislation: The new session of the Iowa General Assembly has begun on a hopeful note with a bill recommended by the Commerce Committee of the House of Representatives which seeks to build on the 1975 enactment of H.F. 803. This new bill (H.F. 179) is awaiting consideration by the full House. Various provisions are contained in this bill which, if not altered by amendment, are acceptable to the Society. Included in these provisions are voluntary binding arbitration, breakdown of verdicts, periodic payments, and strengthening of the Board of Medical Examiners.

Study of the Excess Fund Concept: This request of the 1976 House has been responded to by the adoption of the IMS/Aetna program. The new program provides catastrophe or excess coverage up to \$5 million and thereby alleviates the previous market crisis which existed in this area.

In summary, the Medico-Legal Committee has attempted through another year to maintain its communications with all those concerned with professional liability, e.g., the Insurance Commissioner, the insurance company representatives, other health care providers, plus those outside the health care field who are being hit by this problem. The Society has attempted to assist those member physicians who have submitted coverage questions. Obviously, the year's major breakthrough has been the IMS/Aetna program which at this point presents a basis of reasonable optimism. The success of the program will depend to a large extent on the willingness of the Society's physicians to participate and to engage in those important activities which are needed to preserve the fiscal soundness of the program.

If developments occur in the weeks between the preparation of this report and the meeting of the House which impact on the professional liability climate in Iowa, a supplemental report will be submitted. Thought is now being given to the value of a summary report to the House on the new IMS/Aetna program. A determination on this matter will be made in consultation with the Board of Trustees.

CLARENCE H. DENSER, JR., M.D., *Chairman*

COMMITTEE ON PUBLIC RELATIONS

Although the IMS is not involved in any formal public relations program or theme, the Committee wishes to stress the important public service and public relations aspects of many of its specific interests and activities—e.g., continuing medical education, health education, health planning, professional liability, legislation, liaison with various departments of state government and voluntary health agencies, etc.

The Committee was pleased to note that Iowa newspapers gave considerable space to an article reporting on a recent Gallup Poll which indicates that the American public has ranked medical doctors highest among 11 professional and occupational groups in terms of "honesty" and "ethical standards."

The Committee continues to oversee implementation of the following P/R projects which have proved to be successful the past several years:

HAWKEYE SCIENCE FAIR: The 19th Hawkeye Science Fair is scheduled April 1 and 2 at Veterans Memorial Auditorium in Des Moines. The Fair has become a very popular event, drawing over 700 exhibitors and an audience estimated at 10,000 persons. It provides an opportunity for junior and senior high school students to exhibit scientific research projects and to compete for college scholarships and other awards. The Fair is sponsored by the IMS, the Scanlon Medical Foundation/IMS, the DES MOINES REGISTER AND TRIBUNE, and Drake University.

IN THE PUBLIC INTEREST: The "In the Public Interest" section of the IMS JOURNAL covered various subjects of special interest to the lay public during the past year, including national health legislation proposals, medical malpractice and professional liability coverage, physician manpower gains in Iowa, political action, and physician advertising principles. Reprints of these articles are mailed each month to state newspapers, as well as Iowa legislators.

CONTACTS WITH RADIO AND TELEVISION STATIONS: The IMS cooperates with radio and television stations in securing physicians to participate in programs dealing with health and medical socio-economic subjects.

RELATIONS WITH THE MEDIA: IMS staff members maintain good working relationships with representatives of the mass communications media, including the DES MOINES REGISTER AND TRIBUNE and the wire services, in order to provide them with accurate background for various stories dealing with health programs and issues.

At the Fall Conference for County Medical Society Presidents (October 28, 1976) an interesting panel discussion entitled, "As Others See Us," was included on the program. An attorney from Cedar Rapids, the executive secretary of the Iowa Consumers League, and the Vice President of News and Public Affairs of the Blackhawk Broadcasting Company presented candid and forthright comments on the "public image" of the medical profession. It is anticipated similar presentations will be scheduled in future conferences.

Physicians are reminded their individual efforts—both in providing high quality medical care to their patients, and in assuming civic leadership and responsibilities—constitute the most effective and beneficial "P/R" program for the profession as a whole.

JOHN G. THOMSEN, M.D., *Chairman*

SUBCOMMITTEE ON INTERPROFESSIONAL ACTIVITIES

In 1975, the House of Delegates approved IMS endorsement of a Pharmacy Capitation Pilot Project, developed and sponsored by Blue Cross of Iowa and the Iowa Pharmacy Service Corporation. In essence, the project involves Title 19 recipients in two Iowa counties, and is aimed at making the pharmacist an even more useful member of the health care team by utilizing his knowledge to protect patient health and assist the physician in drug product selection and drug use control. The drug product selection process does not refer to the selection of a specific therapeutic agent, but relates to the selection of the product (brand) of that therapeutic agent.

The pilot project has been approved by the Iowa Society of Osteopathic Physicians and Surgeons, the Iowa Pharmaceutical Association, the Iowa Department of Social Services, and the Boards of Directors of Blue Cross and the Iowa Pharmacy Service Corporation. Involved county medical societies also authorized participation.

The pilot project has been operational since July 1, 1976. The Committee has been advised that although it is too early to determine accurately the effects of the pilot program, some preliminary statistical data is being collected and a progress report will be submitted to the Committee in the near future.

On January 12, a letter was mailed from the IMS to all clinic managers in the state advising of rules and regulations recently adopted by the Board of Pharmacy with respect to unethical practice by pharmacists. In essence, the new ruling allows the Board to lift the license of any pharmacist who is employed by a physician; who leases space for a pharmacy from a physician on a "percentage

of income" basis; or who pays rent that is not reasonable according to commonly accepted standards of the community. The IMS is keeping apprised of further developments in this regard, and is aware that some of the clinics potentially affected by this ruling may investigate the desirability of submitting an appeal to the court.

No joint meetings of the IMS Subcommittee on Inter-professional Activities and a similar committee of the Iowa Pharmaceutical Association have been held during the past year. However, it is anticipated, as soon as a progress report concerning the Pilot Pharmacy Project is available, a joint session will be arranged. This will provide opportunity for representatives of medicine and pharmacy to also discuss the new pharmacy board ruling, and other matters of mutual interest and concern.

The IMS is represented on the Iowa Health Council Board of Directors by V. L. Schlaser, M.D., Donald C. Young, M.D., and Eldon E. Huston, Executive Vice President of the IMS. Mr. Huston also serves as Secretary-Treasurer of the Health Council. The following organizations comprise the Iowa Health Council: Iowa Dental Association, Iowa Hospital Association, Iowa Medical Society, Iowa Nurses' Association, Iowa Health Care Association, Iowa Pharmaceutical Association, Iowa Podiatry Society, Iowa Society of Osteopathic Physicians and Surgeons, and Iowa Veterinary Medical Association.

The Health Council sponsored a special management seminar for representatives and staffs of the member organizations on February 3. That evening the IHC sponsored its annual dinner honoring members of the Iowa General Assembly and other state officials. Representatives of the IMS and the other organizations had opportunity to become acquainted with Iowa legislators during the reception and dinner. Although no formal program was presented, the guests were reminded the IHC represents approximately 14,000 persons engaged in health care delivery in the state.

IMS staff and office facilities are utilized to coordinate and implement the various projects of the IHC.

V. L. SCHLASER, M.D., *Chairman*

COMMITTEE ON SCIENTIFIC WORK

Over 200 physicians attended the 1976 Scientific Session held in Iowa City on April 6, 7 and 8. The program was approved for 14 hours of prescribed credit by the American Academy of Family Physicians, and Category I Credit/AMA Physicians' Recognition Award.

The program for the 1977 Scientific Session is now complete and preliminary information has been provided to the membership. The meeting will be held at Telemark Lodge in Cable, Wisconsin, July 12, 13 and 14. Full details will be published in the May or June issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

J. F. BISHOP, M.D., *Chairman*

COMMITTEE ON STATE DEPARTMENTS

The Committee on State Departments is an entity specified in the governing language of the Society. The Committee exists basically as a parent body for six active subcommittees: Aging and Chronic Illness, Maternal and Child Health, Psychiatric Care, Public Assistance, Rehabilitation and Safe Transportation. Each of these subcommittees has a liaison function with one or more agencies of state government.

Through various means, including the Committee on State Departments, the Society attempts to maintain effective relations with the State Department of Health. State Health Commissioner Norman L. Pawlewski, who is now in his fourth year in that capacity, and his associ-

ates, make important and vital contributions to the delivery of health care in Iowa.

The State Board of Health is a nine-member appointive body which provides the Department with guidance in the conduct of its duties and programs. The physician members of the Board are P. J. Leehey, M.D., Independence; Paul Seeböhm, M.D., Iowa City; A. D. Randolph, M.D., Anamosa; and K. L. Clayton, D.O., Spirit Lake. Dr. Seeböhm is president of the Board.

Public health topics are discussed each month in the JOURNAL OF THE IOWA MEDICAL SOCIETY. We are pleased to advise the communications with the State Department of Health have been continued on a positive basis this past year.

E. E. LINDER, M.D., *Chairman*

SUBCOMMITTEE ON AGING AND CHRONIC ILLNESS

A letter from the Iowa Commission on Aging indicates that "there are presently 508,000 Iowans who are 60 years or older." This accounts for 16.9 per cent of Iowa's population.

A recent survey shows over 60 per cent of this group say "these are the best years of our lives."

Iowa's Senator Dick Clark conducted hearings (Special Committee on Aging, U.S. Senate) around the state in the summer of 1976. Major difficulties voiced by the elderly, in order of their importance, were: (1) housing, (2) nutrition and meals, and (3) transportation (to physician's office, grocery store, church, social events, etc.).

In a prepared statement, Senator Clark said "the Congress needs to know more about what is happening in those counties (certain Iowa counties) and others which have a growing older population and a declining younger population. They (senior citizens) must have a social security system that is fair and adequate, a Medicare program which pays for prescription drugs, and other essentials now left out. Older Americans are using modest federal assistance to work at the community level to meet the needs they feel and see."

E. E. LINDER, M.D., *Chairman*

SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

The Subcommittee on Maternal and Child Health met most recently on February 16 to consider matters of interest. Following is a brief summary of the topics considered:

Statute of Limitations: The Committee voted unanimously to recommend that the medical liability law be revised in a fashion similar to the Indiana law. This would shorten the time to file a claim on behalf of minors to six years plus two. This recommendation was sent to the Legislative Committee.

Immunization: This subject continues to receive principal attention from the Subcommittee. Delegates to the House will recall the policy of the Society is now to support legislation to make immunization against communicable diseases a condition for school entry. Bills (H.F. 163) (S.F. 86) to require such immunization are before the 1977 General Assembly. The Subcommittee is aware that this topic is on the Society's priority schedule but recognizes it does not carry a high classification. The Subcommittee has conferred with Martin Myers, M.D., of the U. of Iowa Pediatric Diseases Department, and with State Department of Health officials over possible strategy to secure favorable consideration of the bill. The Iowa proposal is patterned after the Texas law which is understood to have been particularly effective. Iowa physicians

are urged by the Subcommittee to contact their legislators to express support for the legislation. The Iowa Chapter of the Academy of Pediatrics is strongly supportive of this measure.

Swine Flu Program: While not directly related to maternal and child health, the Subcommittee did participate on a special ad hoc committee to assist in the Iowa phase of this national program. The status of the program is well known. Up to the time of the moratorium on December 16, 1976, approximately 55% of the Iowa population had received the vaccine. The cooperative efforts of the State Department of Health, the Iowa Medical Society and other organizations were responsible for achieving this reasonably high level of coverage. The number of cases of Guillain-Barre reported to the SDH during and following the immunization period is 14, with six of these persons having received the vaccination.

Measles Incidence: The recent and current outbreak of measles in Iowa has been discussed with SDH officials. Because of the appearance of 850 cases in 49 geographically distributed counties, the epidemic designation has been regarded as justified by the Department. The outbreak has been complicated by the scarcity of measles vaccine. Furthermore, indication has come to the Subcommittee that press reports of the measles cases precipitated numerous physician contacts by parents; it is noted that media accounts of these outbreaks cause concern among parents; because of this, it is felt that maximum effort should be made to provide information to physicians in advance of any public dissemination.

Polio Consent: Future supplies of polio vaccine distributed by the SDH to Iowa physicians will have included with them a form which must be signed and returned indicating the physician agrees either to explain to the patient the benefits and dangers of the vaccine or will use an informed consent form. The SDH must now require that informed consent forms be used in all public clinics. This procedure is being required by Lederle which is the only active polio vaccine manufacturer at this time.

Abortion Reporting: The number of abortion reports has declined from 4,000 in 1974 to 2,300 in 1976; this has occurred even though it is believed the number of abortions have not declined. In an effort to formalize the reporting procedure, the SDH has developed regulations to be inserted into the Iowa Administrative Code. The new form to be used will be similar to a birth certificate or fetal death certificate but will not provide for any name. This reporting procedure has been supported by the Iowa Society of Obstetrics and Gynecology and was endorsed by the IMS several years ago as a procedure to be administered by the SDH.

Maternal Mortality Review Committee: This joint body of the IMS, SDH and University of Iowa is chaired by W. J. Balzer, M.D., Davenport. It meets periodically to discuss and review cases in Iowa where a maternal mortality has occurred.

Other topics discussed by the Subcommittee on Maternal and Child Health include (1) the legislation now being considered to require autopsies in the case of sudden infant death syndrome; (2) the recent court rulings which relate to child abuse reporting; (3) the provision of abortion services to a minor without parental consent; and (4) the distribution of nutritional or dietary information to parents of newborns.

It is possible the Subcommittee will share in sponsoring a seminar in 1977 for those physicians who serve as county immunization chairmen. A seminar was presented in 1975 jointly with the State Department of Health and was attended by approximately 60 persons.

GEORGE L. BAKER, M.D., *Chairman*

SUBCOMMITTEE ON PSYCHIATRIC CARE

The Subcommittee on Psychiatric Care has met four times this year and has another meeting scheduled in April. A variety of subjects have been considered. Following are brief descriptions of the major topics:

Legislative Authorization for Mental Health Studies: Now under review by the Iowa General Assembly are materials which call for examination and possible re-vamping of the state's mental health organization, primarily with respect to the four mental health institutes and the local community mental health centers. Several different documents have appeared in recent months which bear on the subject. Included are "Progress Report of Interim Study of MHI and Aftercare to the Joint Subcommittee" (prepared for the respective subcommittees of the House and Senate Committees on Human Resources) and a House Concurrent Resolution, which supports a further (and likely outside) study of mental health delivery. A sum of \$75,000 has been recommended for this study.

The IMS Committee on Psychiatric Care is apprehensive about the thoroughness (or lack thereof) of the evaluation which has been made to date. The Progress Report mentioned above contains little reference (1) to the liaison efforts now being pursued between the MHI and the CMHC's, and (2) to the extent to which psychiatric care is provided in units of Iowa community hospitals. It generally conveys a picture of disorganization in the mental health care field.

The Committee submitted the preceding concerns to the IMS Executive Council in a January 27, 1977 report which was sustained by the Council. As requested, the approved report was distributed to the Governor and various key legislators. The IMS report questions the limited research involved in the governmental considerations, and endorses the need for cooperation between all parts of the mental health delivery system. It does oppose, as has been the Society's policy, the establishment of a separate State Department of Mental Health. This report underscores the need for joint effort between public and private agencies to maximize both the planning and delivery aspects of mental health care.

This distribution of the IMS position paper has touched off some comment from legislators and others. If it does cause state officials and others to reflect on the status of mental health care in Iowa, it will have served a useful purpose. Comments are being received as this report is prepared.

The Committee has considered the following subjects:

Impaired Physicians: The Subcommittee has recorded itself as being willing to provide its expertise in this area in situations where physicians and/or their relatives might have a need for them. One involvement occurred this year when the State Board of Medical Examiners requested the Subcommittee to evaluate a situation and make a recommendation. This was done.

Iowa Commitment Law: This law became operative in 1976. Its advocates believe it will assure more thoroughly than before the legal rights of the potential mental patient. According to isolated reports, the volume of commitments has remained approximately stable since the law became effective. It has drawn some reaction from the magistrates on whom a greater responsibility has been placed.

IMS Mental Health Standards: The Iowa Medical Society developed a set of standards for the guidance use of mental health clinics in the 1960's. These standards have been modified slightly once or twice. The Subcommittee has taken a look at the need to either abandon them or

make a total overhaul. This matter is under study and will dovetail with an examination of new standards prepared by the Joint Commission on Accreditation of Hospitals.

Mt. Pleasant Mental Health Institute: On recommendation of the Committee, the Executive Council approved sending a letter to Governor Ray and Social Services Commissioner Kevin Burns opposing the creation of correctional facilities at the Mt. Pleasant Mental Health Institute. Governor Ray responded with a letter indicating he was required by the Assembly to take an action on this matter and the selection of Mt. Pleasant was the most acceptable alternative.

Iowa Medicaid Program: The Committee devoted considerable time this past year to reviewing and approving criteria for inpatient psychiatric care, particularly out of a concern over ramifications of the Medicaid program. A significant portion of Medicaid expenditures are for psychiatric care and in this connection, the Subcommittee and the Iowa Psychiatric Society have developed review measures and inpatient criteria in an attempt to assure adequate care within reasonable cost parameters. It has been agreed there will be benefit in having a psychiatric consultant serve each peer review committee of the Iowa Foundation for Medical Care. The idea of developing outpatient care criteria remains under study. This project is being pursued by the Iowa Psychiatric Society.

Several additional matters have been considered briefly by the Subcommittee: (1) the emergence of a new body known as the State Mental Health Coalition; (2) enactment in several states of legislation requiring mental health services be included in health insurance coverage; and (3) several local situations where mental health programs have caused concern.

H. L. NELSON, M.D., *Chairman*

SUBCOMMITTEE ON PUBLIC ASSISTANCE

The activity of the Subcommittee on Public Assistance remains concentrated on the Iowa Medicaid Program. At this time interest centers on the amount of supplemental funding the General Assembly will allow to complete this fiscal year. The State Department of Social Services asked for an additional \$9 million. The sum approved at the legislative committee level is \$8 million. A supplemental appropriation of \$13 million was authorized last year.

In addition to money for the balance of the current fiscal year, the Assembly must appropriate funds for the new fiscal year which begins July 1. The askings vary here from \$84 million, which is the asking of the Department of Social Services, to \$74 million, which is the figure in the Governor's budget.

Medicaid expenditures in 1976 totaled \$142.6 million with 57% of this in federal funds and 43% in state and local resources. Of this, \$11.3 million (7.96%) was paid to medical doctors. Other expenditures by percentage included intermediate care facilities—46%; inpatient hospital—17%; pharmacies—6%, and dentists—4%.

The Society was represented at a December 21, 1976, meeting of the Medicaid Advisory Council. It was indicated at that time that the private audit firm of Haskins and Sells had completed its analysis of the Iowa Medicaid Program. Some 40 recommendations were contained in the final report with the services of Haskins and Sells being continued to assist in the implementation of various of the suggestions.

Insofar as physicians' services, the Haskins and Sells Report contains little of consequence. A major information dissemination program has been recommended to

identify patterns "of excess medical utilization delivered or prescribed by the individual physicians." The report continues, "These patterns should be the subject of specific follow-up with the physician involved, as well as disseminated to all physicians. This should be in the nature of an educational, not a punitive, process and, therefore, any discussion other than with an individual physician should not identify the physician involved."

The attention given nationwide to Medicaid fraud among providers and recipients is receiving consideration in Iowa. The Society is aware that the Bureau of Criminal Investigation has assigned three persons to the DSS to check into potential provider abuse. Reports indicate some action may be brought soon against providers found to be in violation of the program.

The level of federal participation in the Medicaid program will decrease from the present 57% to 51% in October. This decline in federal support will require a substantial additional state commitment over the next several years. The degree to which the legislature will accept this responsibility is uncertain and will obviously have a definite expansionary impact on the Iowa tax picture.

In February eligibility criteria for home care under Medicaid was broadened. Services have been extended to patients needing maintenance care using this definition: "Health Maintenance—Patient's condition is stabilized. Needs physician plan of treatment, the review interval to be decided by physician on an individual basis. . . ." This change should make Medicaid-reimbursed home care available to numerous additional patients.

The matter of federally required care review of intermediate care facilities is of concern to the SDSS in terms of compliance. Some discussion has occurred with the Iowa Foundation for Medical Care in terms of subcontracting to perform this service. No decision has been reached.

Deficiencies in that phase of the Medicaid program which involves the early and periodic screening of children to age 21 have been noted. It is necessary for this program to be fully operative for the state to receive federal funding. An advisory committee to include representatives from 12 provider groups has been suggested to review the deficiencies in this program. This would include the IMS.

The Society and the Subcommittee will continue to follow developments in the Iowa Medicaid Program.

A. J. HAVLIK, M.D., *Chairman*

SUBCOMMITTEE ON REHABILITATION


A joint meeting of the Subcommittee on Rehabilitation and the Committee on Industrial Health occurred January 19, 1977, with the State Industrial Commissioner and several of his departmental associates.

The meeting was given over to a review of the current status of the Workers' Compensation with suggestions as to ways in which the medical aspects of the program might be made more effective and efficient.

A tentative plan has been developed to assist Iowa physicians in achieving a better understanding of the WC program. Included in the plan are several articles in the IMS JOURNAL, and the availability of speakers from the State Industrial Department to participate in county medical society meetings.

Efforts to implement the program are now in process with a follow-up meeting with Commissioner Robert Landess scheduled in the fall.

W. D. DEGRAVELLES, JR., M.D., *Chairman*



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SUBCOMMITTEE ON SAFE TRANSPORTATION

Excellent working relations continue to exist between officials of the Iowa State Department of Transportation and the IMS Subcommittee on Safe Transportation. To date, approximately 100 cases have been reviewed by the Medical Advisory Board created by the IMS to make recommendations on medical case files of driver's license applicants who have been required to submit medical reports to the DOT for various reasons. The recommendations of the Board are considered by the DOT in determining whether to approve such applications.

In response to a law enacted in 1976, which was supported by the IMS, driver's licenses have been redesigned to include space for both "medic-alert" and "organ donor" decals. This information will serve to alert highway patrol officers, emergency medical personnel, and others that an individual may have a specific medical problem which requires special attention or may be an organ donor; hence, further attention and investigation are necessary.

The Committee reaffirmed IMS support of basic "Principles and Recommendations" relating to ambulance services and facilities, and the enactment of appropriate ambulance legislation designed to eliminate substandard ambulance operations. The principles and recommendations were developed in 1969 as guidelines for developing legislation pertaining to the organization and operation of ambulance services.

At its November meeting, the Committee reviewed information concerning the use of human restraint systems in motor vehicles, with special attention to the air bag. A film shown to the Committee, along with supplemental material provided by a Committee member, demonstrated

that although the air bag is effective in straight-on crash situations, problems develop in many other crash situations depending upon the speed of the vehicle, the site of the impact, and other factors. In addition, there are certain design problems associated with the use of air bags that have not been resolved—e.g., the bag is designed to "explode" at 10 mph impact; climate affects the bag so periodic replacement is required; the installation of an air bag for front seat occupants will increase the cost of a car a minimum of \$200.

The following recommendation of the Committee was submitted to and approved by the IMS Executive Council in January 1977: "That the IMS oppose the mandatory use of passive restraints, such as air bags, in motor vehicles." A report regarding this action has been submitted to Iowa's congressional delegation in Washington, and also to the AMA.

The Chairman of the Committee met with AMA representatives and an official of the DOT in mid-July to review the activities of the Medical Advisory Board to the Iowa DOT. The Committee was commended by the AMA for establishing a close and effective liaison with state highway and transportation officials.

The Committee Chairman has accepted an invitation to represent the IMS on a Citizens Motor Vehicles Advisory Council appointed by the Motor Vehicle Division of the DOT. When the Chairman of the Committee cannot attend Council meetings, other members will be requested to do so.

The Committee intends to continue to confer with DOT officials on matters of mutual interest and concern, and to keep apprised of pertinent legislative issues.

A. H. DOWNING, M.D., *Chairman*

PUBLICATIONS COMMITTEE

A signal honor was bestowed on the JOURNAL OF THE IOWA MEDICAL SOCIETY in 1976. The JOURNAL was selected as a winner in the national competition sponsored by Sandoz Pharmaceuticals. Judges in the competition named the IMS JOURNAL as best among those state publications in the under 3,000 circulation category. A plaque and a check for \$500 were presented to the Society by Sandoz representatives. Those connected with the production of the JOURNAL were gratified and honored to be recognized in this manner.

It is the custom in this report to note that the IMS JOURNAL is the official publication of the Society and is published 12 times each year. Its goal is to provide member physicians with worthwhile scientific and socio-economic information. It has value in terms of historical importance. Hopefully, it will provide a useful reflection of the times to those who choose to look back from some point in the future.

It is appropriate to express appreciation to the various physician authors who have submitted papers to the JOURNAL. We have been gratified by the slight increase in scientific writing by physicians who practice outside the academic setting. This is an apparent reflection of the increased impetus on continuing medical education. While the preceding is noteworthy, the U. of I. College of Medicine continues to be a principal source of scientific material. We are indebted to Richard M. Caplan, M.D., Associate Dean for Continuing Medical Education, for his efforts in behalf of the JOURNAL.

It is our practice in this report to request member physicians to forward editorial ideas, case reports, scientific manuscripts and news items. We do so in closing with the notation they will receive careful consideration.

MARION E. ALBERTS, M.D., *Scientific Editor*

Reports of Special Committees

COMMITTEE ON ALCOHOLISM AND DRUG ABUSE

In light of many common interests and concerns, the previously separate IMS Committees on Alcoholism and Drug Abuse were combined last year.

F. W. Bennett, M.D., Co-Chairman of the Committee, has served on a Governor's Task Force on Alcoholism and Drug Abuse since November 1975. This Task Force is concerning itself with the prospective merger of the Iowa Drug Abuse Authority and the Iowa Division on Alcoholism into one state agency. Legislation (H.F. 1514) was passed last year to permit this merger either by July 1, 1977, or January 1, 1978. The 1976 legislation specified that the new agency be a division in the Department of Health. However, as the Task Force has continued its development of further necessary legislation, it has recommended an independent state department to be known as the Iowa State Department of Substance Abuse. Under this plan, the Department would be headed by a director to be appointed by the Governor and confirmed by the Iowa Senate. The IMS Committee will follow these state-level organizational developments with interest.

At a November meeting the Committee acknowledged that one of its primary objectives is to inform and educate member physicians about problems related to the diagnosis and treatment of alcoholism, and problems related to drug abuse. As part of the educational program, the Committee, with assistance from the Division on Alcoholism/State Department of Health, will send two articles on these subjects to all IMS members.

The first article is entitled "The Causes and Clinical Effects of Drug-Alcohol Interactions" by Frank Seixas, M.D., Director of the National Council on Alcoholism. Doctor Seixas discusses the interaction of alcohol with many clinically prescribed drugs, including antibiotics, anticoagulants, psychoactive drugs, and others. He stresses that since these interactions often are synergistic or additive, the pharmacist and physician should be cautioned about the use of alcohol by individuals taking other medications, and also about the difficulty of determining the extent of a patient's alcohol ingestion.

The second article deals with "Early Recognition of Alcoholism and Other Drug Dependence" by Richard Heilman, M.D., Chief of the Drug Dependency Treatment Program at the Veterans Administration Hospital in Minneapolis. Doctor Heilman emphasizes that alcoholism is a form of drug dependency. He discusses the four important characteristics of drug dependency; he lists eight symptoms of alcoholic-type drinking that should be looked for in the alcoholic; and he calls attention to the potential serious consequences of prescribing mood-altering drugs for an alcoholic seeking help for his drinking problem.

The Committee believes it would be beneficial to increase the emphasis on teaching programs concerned with the treatment of alcoholic and drug-dependent patients. This matter will be discussed with representatives of the University of Iowa College of Medicine.

Representatives of the Committee attended the 4th Annual Iowa Conference on Substance Use and Misuse on December 2-3 in Des Moines. This was sponsored by the Iowa Drug Abuse Authority in cooperation with the Iowa Division on Alcoholism.

Early in the fall, each member of the IMS was provided a copy of a "Directory of Iowa Drug Abuse Services" made available by the IDAA.

Staff representatives of the Alcoholism Commission and Drug Abuse Authority will be invited to attend the next meeting of the Committee to discuss the anticipated merger of these two agencies and other matters of mutual concern.

F. W. BENNETT, M.D., AND

S. M. HAUGLAND, M.D., Co-Chairmen

COMMITTEE ON ALTERNATE DELIVERY SYSTEMS

The Committee on Alternate Delivery Systems met on January 26, 1977, to receive a report from officials of Blue Cross/Blue Shield and Rural Health Services of Bloomfield, Iowa, relative to the first year of operation of Rural Health Services (RHS), as a health maintenance organization (HMO).

Initial marketing began in November, 1975, and the program began operation in December, 1975. The enrollment is approximately 4,000, primarily from Davis County.

A first-year financial loss is not unusual for an HMO but officials were surprised by the magnitude of the RHS loss of over \$400,000.

RHS and Blue Cross/Blue Shield officials have analyzed the operation and pinpointed the trouble spots. They are taking steps to correct the problems and bring RHS to a break-even status during the second year of operation.

Some of the major factors contributing to the deficit were:

(1) Enrollment for '75-'76 was open to all applicants regardless of past medical history, pre-existing conditions, etc. There was also the "pent-up" need for medical and/or surgical care that manifests itself during the first months of this kind of operation.

(2) The cost per enrollee for inpatient surgery was more than triple the anticipated cost (\$1.01 expected, \$3.10 actual).

(3) The number of admissions per 1,000 and the inpatient days per 1,000 were greater than expected. Figures from the first eight months of experience were: Admissions per 1,000—expected 100, actual 248; inpatient days per 1,000—expected 650, actual 1,394.

(4) Through the first eight months the average in-hospital allowance per day exceeded expectations by \$10.64. (Expected \$118.00, actual \$128.64.) The RHS report noted this figure will change due to \$7.00 per day increase in room rates.

(5) RHS benefits include payment for drugs. The utilization for this portion of the program was greater than expected.

(6) Referral costs (first eight months) were \$123,000.00, twice that expected.

(7) Contract (membership) costs turned out to be too low. The costs per month were: single contract \$30.00; family contract \$69.00.

Several steps have been taken or are in the process of being implemented to maintain the program on a break-even basis.

These include—(1) Education of both enrollees and providers; (2) Development of risk sharing with the clinic and a per diem arrangement with the hospital; (3) Utilization review utilizing perimeters of treatment by diagnosis; (4) Revenue audits of charges; (5) Develop more outpatient surgery, and (6) New enrollment including Medicare, Medicaid patients and include more Missouri patients. New enrollees will be accepted on an underwritten basis as opposed to first year open enrollment.

Mr. David Neugent, president of Blue Cross, reported on several cost saving medical programs currently in progress or operative as pilot programs by Blue Cross/Blue Shield.

ERLING LARSON, JR., M.D., *Chairman*

COMMITTEE ON ARCHITECTURAL EDUCATION

The Committee on Architectural Education has not had occasion to meet this year. However, it will continue to serve on a stand-by basis, and will be available to meet with representatives of the Iowa Chapter/American Institute of Architecture to discuss matters related to the design and construction of health facilities.

W. R. BLISS, M.D., *Chairman*

COMMITTEE ON BLOOD BANKING

Society President James Bishop recently referred a letter from the "Prairie Region Affiliated Blood Services" which has temporary headquarters at the Mississippi Valley Regional Blood Center in Davenport, Iowa. The letter enclosed an unsigned organizational agreement which proposed to take in four not-for-profit community-based blood centers in Davenport, Ottumwa, Iowa City, and Galesburg, Illinois.

The letter alluded to the challenge of the American Blood Commission, and more specifically to its "Special Task Force on Regional Association of Blood Service Units," urging voluntary affiliations of blood services to assure an adequate supply and efficient distribution of safe high quality blood and blood products.

By their active participation in the organizational proposal, the University of Iowa has indicated interest and the "Prairie Region" has requested endorsement of the Iowa Medical Society. The Committee will consider the proposal and refer it to the Board of Trustees with recommendations.

Blood services in Iowa have been expanding and the resources are available within the state to meet University needs provided coordinated regional planning becomes a reality.

W. S. PHETEPLACE, M.D., *Chairman*

COMMITTEE ON COMMUNITY EMERGENCY MEDICAL SERVICES

The 1976 House of Delegates considered this resolution from the Dubuque County Medical Society: "Resolved, that a plan for developing a disaster support system of physicians on a volunteer basis be developed. They could be transported by the U. S. Air Force on a 24-hour notice to any place in North and South America for disaster relief."

The House endorsed the concept of a disaster support system of physicians on a volunteer basis, and directed that the resolution submitted by Dubuque County be called to the attention of the Governor's Advisory Council on Emergency Medical Services for its information and consideration. A copy of the resolution was also provided to the American Medical Association.

In response to the resolution, the IMS has been advised

that the Agency for International Development (AID) is the responsible agent for the U. S. when volunteer physicians are needed in disaster situations in various locations in the world. According to the AID deputy director, the agency serves as a conduit with such organizations as the AMA in providing information on the types of specialized services needed in a country where a disaster occurs. The director states it has been determined over the years that volunteer physicians should only be deployed when there is a clear need for their services, and when there is also the necessary logistical support to back up the activities of volunteer physicians.

Three physicians are currently serving on the Governor's Advisory Council on Emergency Medical Services: William R. Bliss, M.D., Secretary of the IMS, is Interim Chairman of the EMS Council; M. E. Abrams, M.D., and R. D. Eckoff, M.D., both of whom serve on the IMS Committee on Community Emergency Medical Services.

According to a recent report from the Council, much progress has been made in improving EMS services in Iowa. Hospital emergency medical capabilities have been categorized, and many hospitals have upgraded their services. Coordinated communications systems have been implemented in two areas of the state, and in other areas planning efforts are underway to facilitate citizen entry into the system and to allow two-way communications between law enforcement officers and ambulance personnel, physicians, and other hospital emergency department personnel. Many new ambulances have been purchased, as have medical equipment items necessary for the provision of care at the scene and en route to an emergency medical service facility or critical care unit. More than 4,000 ambulance personnel have completed the Iowa State Department of Health's Emergency Medical Technician-Ambulance (EMT-A) training course administered through the area community colleges. In addition, the EMS Plan established procedures for the development of comprehensive emergency medical service programs at the regional and local levels.

As noted in the report of the IMS Committee on Safe Transportation, a bill requiring ambulance services to maintain minimum standards and providing a funding mechanism for the establishment of services has been introduced to, but not enacted by the Iowa Legislature. The IMS supports basic principles and recommendations which have been developed with respect to ambulance services and facilities, and the enactment of appropriate legislation designed to eliminate substandard ambulance operations.

The IMS was recently advised that the EMS section of the State Department of Health is now in the process of re-examining the Statewide Emergency Medical Services Communications Plan. Meetings will be held throughout the state to discuss communications needs of EMS provider agencies; proposed development of an EMS resource dispatch system which utilizes the facilities of the county communications centers; and medical control of emergencies through the utilization of regional coordination centers and regional EMS duty physicians. At the conclusion of these meetings, any proposed changes to the Communications Plan will be presented to the IMS and other organizations for review and comment.

A. H. DOWNING, M.D., *Chairman*

COMMITTEE ON DELEGATION OF AUTHORITY

Although no sessions have been held during the past year with representatives of the Iowa Nurses' Association and Iowa Board of Nursing, a meeting will be arranged in the near future to consider joint statements on the

drawing of blood gases by nurses and standards of nursing practice in hemodialysis units. When the statements are in final form, they will be submitted to the IMS Executive Council or House of Delegates for approval.

In previous years the IMS, INA, and Board of Nursing have issued joint statements on the following subjects: (1) Nursing Functions for Registered Nurses Practicing in Hospitals or Organized Agencies in Iowa; (2) Intravenous Administration of Fluids and Medications by Professional Nurses Practicing in Hospitals or Organized Agencies in Iowa; (3) Ear Piercing.

Last spring the Iowa Legislature passed a bill relating to the practice of nursing and providing for disciplinary procedures. The Committee met with nursing representatives on three occasions to discuss various aspects of the bill when it was in draft form and offered several recommendations regarding certain sections of the bill, especially with respect to a definition of the term "diagnosis and treatment." As the bill was finally enacted, the "practice of the profession of a registered nurse," as licensed by the Board of Nursing, was defined as follows: (a) formulate nursing diagnosis and conduct nursing treatment of human responses to actual or potential health problems through services such as case finding, referral, health teaching, health counseling, and care provision, which is supportive to or restorative of life and well-being; (b) execute regimen prescribed by a physician; (c) supervise and teach other personnel in the performance of activities relating to nursing care; (d) perform additional acts or nursing specialties which require education and training under emergency or other conditions which are recognized by the medical and nursing professions and are approved by the board (of nursing) as being proper to be performed by a registered nurse; (e) apply to the abilities enumerated "a" through "d" of this subsection scientific principles, including the principles of nursing skills and of biological, physical, and psychosocial sciences.

Last spring, John Rhodes, M.D., a member of the Committee, appeared on a special television program over WOI-TV, Ames, to discuss the proposed amendments to the Nurse Practice Act and other related matters—e.g., the expanded role of the nurse, the Family Nurse Practitioner Program, and the work of the liaison committee of the IMS, INA, and Board of Nursing.

As reported to the House last spring, the Family Nurse Practitioner Project, sponsored by the IMS and Iowa Hospital Association, with funding from the now defunct Iowa Regional Medical Program, was officially completed on September 26, 1975, when six registered nurses graduated from the FNP program at the University of North Dakota School of Medicine.

In a progress report recently provided to the IMS, it was reported that all six FNP's in the pilot program have passed the National Certification Examination for Primary Care Physician's Assistants. The employer of one FNP applied for, and received, approval from the Board of Medical Examiners customarily given PA's. Others regard the current nurse practice act in Iowa, along with their authority to delegate tasks to an employee, as an adequate legal basis for the employment and use of an FNP.

Four of the six FNP's are still employed on a full-time or part-time basis in offices of their preceptor physicians. A fifth FNP is working in the out-patient clinic of a Des Moines hospital, and the sixth FNP is employed as a public health nurse. Four of the FNP's originally worked in a satellite office of their supervising physician. While these satellite offices are still operational, none are staffed by FNP's. Three are staffed by one or more physicians rotating from a larger town, and one is staffed full-time

by a PA who is supervised by physicians in a nearby community.

In May, 1976, seven additional Iowa nurses enrolled in the University of North Dakota FNP Program and have Iowa family physicians as their preceptors. The cost of their training is being paid by the nurses, some with assistance from their individual preceptors.

The Committee plans to continue to maintain liaison with representatives of the INA and Board of Nursing to discuss projects and issues of interest to our two professions.

L. F. STAPLES, M.D., *Chairman*

COMMITTEE ON DELIVERY OF HEALTH SERVICES

At its session last May, the House of Delegates approved a Committee recommendation that it conduct a study of the utilization and role of physician extenders (physician's assistants and family nurse practitioners) in Iowa, and submit a report on this subject, including general conclusions and recommendations, to the House of Delegates in May 1977.

The Committee met three times during the past year, and has studied various informational and resource materials, including the following: AMA reports concerning physician extenders; correspondence with Senator Dick Clark regarding proposed legislation which would "allow Medicare reimbursement to health clinics where extenders provide primary health services"; a "Study of Attitudes Toward Utilization of PA's in Iowa" completed by a hospital administrator in Chariton, Iowa; status report concerning the PA program in operation at the Muscatine Community Health Center; a progress and evaluation report concerning the family nurse practitioner program in Iowa; and an interim report concerning the training and utilization of physician extenders in Iowa.

In addition, the Committee has involved representatives of the University of Iowa College of Medicine, the State Board of Medical Examiners, and Blue Cross/Blue Shield in its information-gathering meetings.

As the Committee has considered materials and information provided to it, it is clear there are opposite points of view regarding the future role for physician extenders. In the main there is the feeling that physician extenders can provide an important service to physicians and their patients, and in extending and ensuring availability of needed services to patients; however, there is also much concern about maintaining the high quality of care and the threat of "independent practice" by physician extenders.

The Committee has not yet completed its work in connection with this study; however, a detailed supplemental report will be prepared and submitted to the House of Delegates in May, with specific conclusions and recommendations.

In reference to health planning activities, it should be noted that two members of the Committee serve on the Board of Directors/Iowa Health Systems Agency—i.e., John Tyrrell, M.D., Manchester, and L. O. Ely, M.D., Des Moines. Doctor Tyrrell is vice-president of IHSA, and also serves as a member and vice-chairman of the State Health Coordinating Council. Other physicians serving on the IHSA Board are Paul Seebom, M.D., Iowa City, and Russell Gerard, M.D., Waterloo. Approximately 25 physicians are active on the boards of directors of the five subarea advisory councils to IHSA. Reports concerning health planning developments in the state are routinely mailed from the IMS headquarters office to these individuals, as well as to members of this Committee and officers of the Society. Frequent reports are also published

in the IMS UPDATE which is mailed each month to the entire membership.

The U. of I. College of Medicine has provided the IMS with positive information regarding the training and retention of primary care physicians in and for Iowa. There are now seven community-based family practice residency training programs in the state. They are located in Des Moines (2), Iowa City, Cedar Rapids, Davenport, Mason City, and Sioux City. In addition, an eighth program in Waterloo is under development. In 1976, 15 of 24 "graduating" residents elected to remain in Iowa to practice medicine; of these, 10 have located in towns of 9,000 or less.

Information regarding the physician manpower situation in Iowa was summarized in the December issue of the IMS JOURNAL, and reprints were provided to all members of the Iowa legislature, and to all newspaper editors in the state.

The IMS and the College of Medicine work cooperatively in physician recruitment and placement activities. Cooperation and liaison has been established to enhance the effectiveness of programs in both institutions. In addition, the IMS, on recommendation of the Committee, is participating in the Health Personnel Information Services Systems established by the Health Manpower Project/State Office for Planning and Programming.

The System was funded on a pilot basis (July 1976-July 1977). An evaluation will be undertaken in July to determine whether or not it should be continued. In essence, the System serves as a clearinghouse for the collection and dissemination of information regarding health personnel seeking practice locations in Iowa, and communities and others seeking health personnel. Approximately 40 state health agencies and organizations are participating in the project. John Tyrrell, M.D., represents the IMS on the System Board of Directors and Steering Committee.

Last fall representatives of the Committee participated in a conference on "How to Succeed in Recruitment of Health Manpower" sponsored by the Health Manpower Project/OPP, with funding from HEW. The IMS was represented on the program committee, and was responsible for securing Bond Bible, Secretary to the AMA Council on Rural Health, as a keynote speaker.

The Committee will continue its interest in the broad area of the "delivery of health services" to Iowa citizens. It stands ready to meet at any time with appropriate state officials and agencies, and voluntary provider organizations to discuss various activities and projects in this regard.

MAX OLSEN, M.D., *Chairman*

COMMITTEE ON EYE CARE

As reported to the 1976 Iowa Medical Society House of Delegates, the optometrists are actively gathering support for proposed legislation to allow use of diagnostic drugs by optometrists. The Iowa Medical Society is cooperating with the Iowa Academy of Ophthalmology in opposing the bill. Introduction of the bill has not occurred as this is prepared. Opposition to the expansion of the Optometric Practice Act is one of the priorities of the IMS Committee on Legislation.

Officials of John Deere have informed the Iowa Medical Society that a new vision care program has been negotiated through the United Auto Workers. The program will become effective on March 1, 1977. The services of ophthalmologists and optometrists will be covered under an indemnity payment plan. Indications are indemnity payments for an examination will be paid at the rate of \$25 to an ophthalmologist and \$20 to an optometrist.

The University of Iowa College of Medicine reports in the past five years 16 ophthalmologists graduating from the training program have remained in Iowa. This represents a 30 per cent retention rate. In the past 26 years, the number of ophthalmologists per population has doubled in the United States.

National standards have been developed for trained allied health personnel. These personnel are categorized as: ophthalmic assistant A; ophthalmic assistant B; ophthalmic technician, ophthalmic technologist, and orthoptist.

A. H. DOWNING, M.D., *Chairman*

COMMITTEE ON GROUP INSURANCE

While it has not directly involved the Committee on Group Insurance, the new IMS/Aetna Professional Liability Insurance Program is the most significant new development this year in Society-sponsored insurance coverage. This program becomes officially operative on March 15, 1977. The IMS Medico-Legal Committee has given extensive time to this project.

In addition to approving this liability insurance package, the Society has maintained its various coverages for the voluntary participation of interested member physicians.

The Prouty Company of Des Moines is providing able administration for the largest number of the Society's group coverages. The company has sought to maintain and improve its communications with insureds, in addition to bringing information to all member physicians. Informational meetings have been held with various physician groups to review the IMS-sponsored programs and to present estate planning material. In November a special summary of the Society's group coverages was published in the IMS JOURNAL and reprints have been prepared for follow-up use.

Continued improvement in the loss ratio of the Disability Income Plan occurred in 1976. Various corrective steps have been taken to accomplish this improvement. Several additional improvements were made in the program in 1976. A rehabilitation rider was added to all policies at no additional cost. This allows an insured to elect voluntarily an expense paid special rehabilitation program, mutually agreed upon by him and the company, and aimed at returning the insured to productive work. Use of the program does not jeopardize disability benefits.

The Future Purchase Option was also introduced as an improvement to the Disability Program. This option allows the insured to purchase up to a maximum of \$300 weekly in additional benefits. This option is available at two-year intervals between ages 28 and 42 regardless of health conditions. This valuable benefit is provided for a one-time charge which is included as a part of the initial premium. This is an option of importance to younger members and should be an inducement to their participation.

The Prouty Company will hold an open enrollment for the Disability Program in 1977. This will permit all uninsured members under the age of 45 to obtain a \$100 weekly indemnity under the Basic Plan regardless of past medical history. The enrollment will be handled on an area basis so more opportunity will be available to provide personal service.

The IMS Office Overhead Plan showed an improved loss ratio in 1976 because of increased participation. Many members have enrolled in this program since the benefits provide for the payment of professional liability premiums in the event the insured is disabled. Another enrollment period is expected in 1977.

A serious problem with the IMS Excess Major Medical Plan has been resolved. The Prouty Company offered automatic transfer from the Group Excess Plan underwritten by the Northwestern National of Milwaukee, Wisconsin, to the new Improved Excess Major Medical Plan of the Insurance Company of North America. Benefits and rates under the new plan are the same except for elimination of the family deductible. An additional new deductible of \$50,000 is being offered for the benefit of members who have a "high benefit" basic Major Medical Program. A mailing on this program is expected in 1977.

The Accidental Death and Dismemberment Program was also improved in 1976. A new family plan benefit was introduced to allow inclusion of all family members where before only members and their spouses were included. The rates were also reduced 10 cents per \$1,000 in the 1976 open enrollment period. Increased participation occurred in 1976.

The Society's Group Life Insurance Plan also continued to expand in 1976. There was increased volume in both the Term Life and Permanent Life coverages.

On November 15, 1976, a mailing was sent to member physicians on the Statewide Physicians Group Health Program offered by Blue Cross/Blue Shield. This advised of the program's experience over the past 12-month period and set forth the new rates which became effective in 1977. The income for the period reported was \$187,976.14 for Blue Cross and \$168,426.05 for Blue Shield. The outgo was \$216,167.20 for Blue Cross and \$190,349.79 for Blue Shield. The resulting loss was noted as \$28,191.15 for Blue Cross and \$21,923.74 for Blue Shield. As a consequence of this utilization, the new monthly rates were announced as \$33.20 (single) and \$86.10 (family) for the higher level benefits and \$27.35 (single) and \$69.30 (family) for the lower level benefits. There are approximately 650 contracts active under this program.

The Workmen's Compensation Savings Program begun in 1974 has enrolled additional physicians. As of September 30, 1976, there were approximately 30 clinics or individual physician's offices participating in the program. Distribution was made in the fall of \$2,058.35 in dividend checks to those insured under the program.

R. S. GERARD, M.D., *Chairman*

HISTORICAL COMMITTEE

The Historical Committee continues to encourage county medical society officers and individual physicians to maintain records of their activities and prepare manuscripts dealing with the history of medical practice and medical society organizations in their areas.

The Committee has developed some guidelines on how to collect, organize, edit, and publish material dealing with medical history, and these will be made available to interested physicians. Physicians who are interested in recording medical history are encouraged to make use of county medical society meeting minutes, tape-recorded visits with older physicians in the area; research conducted through area newspaper editors, librarians, and historical societies.

Late in November, a letter was sent to all county medical society presidents and secretaries requesting the names of any physicians interested in medical history be provided to the Historical Committee. Approximately 25 physicians have responded, and they have been invited to meet with the Committee at IMS Headquarters on April 6 to discuss medical history writing projects.

As reported to the House of Delegates previously, the IMS will, as a service to its members, reproduce limited

quantities (25-50) of historical papers for use both by the physician author and the IMS.

P. E. HUSTON, M.D., AND

W. H. LONGWORTH, M.D., *Co-Chairmen*

COMMITTEE ON INDEPENDENT LABORATORIES

The activity of the Committee on Independent Laboratories has been limited essentially to monitoring developments impacting on this area of medical care delivery. The national references to the presence of fraud in the provision of Medicaid and other governmentally-reimbursed services by laboratories is disheartening. It is believed that the existence of those practices is nonexistent in Iowa.

Federal efforts to revise the Clinical Laboratory Improvement Act are being followed to the extent possible. Passage of this legislation would impose greater federal regulatory powers over laboratories.

The activity of the State Hygienic Laboratory in terms of locating in new facilities has been noted. So far as is known, this move is still in the planning stage and will require a sizable state appropriation.

G. R. CLARK, M.D., *Chairman*

COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health met jointly with the Committee on Rehabilitation January 19, 1977, to confer with Industrial Commissioner Robert Landess and his associates.

A thorough review was made of the current status of the Iowa Workers' Compensation Program. Concern has been expressed by the Commissioner over the inability to obtain medical information needed in the adjudication of cases which come to his Department. The Commissioner is anxious to have the Society's cooperation and input as to how physician understanding of the WC program might be increased.

To this end, the Committee has devised a tentative educational program which includes (1) several articles for the *IMS JOURNAL*; (2) the encouragement of county medical societies to devote a regular meeting to this subject; and (3) consideration of ways to revise and improve the informational forms which physicians are now asked to complete.

It is anticipated the follow-up meeting with the Industrial Commissioner will be scheduled in the fall.

SIDNEY BRODY, M.D., *Chairman*

MD-DO LIAISON COMMITTEE

A meeting of the Committee is scheduled for February 24, 1977. Members of the two societies will discuss mutual legislative opportunities and problems.

Approximately 30 osteopathic physicians and surgeons are active dues paying members of the Iowa Medical Society and several others are members of various county societies.

J. M. RHODES, M.D., *Chairman*

MEDICAL ASSISTANTS ADVISORY COMMITTEE

It is a pleasure to report that Jeanne Green, CMA-A, who has been my medical assistant for over 25 years, was elected President-Elect of the American Association of Medical Assistants last fall.

Mrs. Green has given a great amount of time and talent to both the state and national organizations of medical assistants, and is well-deserving of this great honor. She will be an outstanding leader of the 18,500 AAMA members who work under the direct supervision of licensed

physicians. These medical assistants serve as a direct link between the doctor and his patients, his colleagues, and suppliers of pharmaceutical products and medical equipment.

Effective in January, 1977, approved seminars, workshops, and other programs will provide opportunity for medical assistants to obtain continuing education units.

Information regarding activities of the local and state chapters of AAMA is presented each month in a special section of the *IMS JOURNAL*.

Officials of the IMS are invited to attend annual sessions of the Iowa Association of Medical Assistants, and it has been my privilege to represent the Society at several meetings in past years.

JAMES F. BISHOP, M.D., *Chairman*

COMMITTEE ON MEDICINE AND RELIGION

The Committee on Medicine and Religion did not have an opportunity to meet during the past year. However, it wishes to remind the membership that physicians should make an effort to get together on a formal or informal basis with local clergymen to discuss mutual patient care problems. Enhancing communication and rapport between the doctor and the clergyman can lead to more effective care and treatment of the "whole" patient.

In past years, subjects relating to medicine and religion have been presented at IMS Scientific Sessions, and have been very well attended and received. The Committee will recommend that a medicine/religion topic be included in the program for the 1978 Scientific Session. In addition, consideration will be given to arranging a special Prayer Breakfast in conjunction with the 1978 program.

The Committee stands by to assist any county medical society in developing medicine and religion projects at the local level, and would be happy to participate in any joint program involving physicians and clergymen.

O. E. SENFT, M.D., *Chairman*

COMMITTEE ON ONCOLOGY

The Iowa Medical Society has cooperated this year with John Berg, M.D., Director of the Iowa Cancer Epidemiology Research Center, in the publication of Iowa cancer data in the *IMS JOURNAL*. These brief statistical reports have covered such areas as cancers of the cervix and breast.

The Committee has been mindful of the attention given in the media and elsewhere to the use of mammography and thermography in the detection of breast cancer. In the August, 1976, issue of the *IMS UPDATE*, reference was made to a position statement on mammography issued by the American College of Radiology. This statement declares, in summary, there is no scientific evidence on (1) the optimal age for the initial mammogram, (2) the frequency of examination, or (3) the long-term radiation risk. Consequently, the College says, because mammography is the most effective diagnostic tool developed for detection of early stage breast cancer, it should continue to be part of the evaluation of a patient with symptoms or physical findings suggestive of breast cancer. In screening asymptomatic women, the first or baseline mammographic exam should be between ages 35 and 40; subsequent examinations should be at one to three-year intervals unless greater frequency is warranted clinically.

The Society has received an inquiry or two this year on the use of mobile detection units and thermography. The response to these questions has been to the effect that thermography is a complementary diagnostic tool that may be useful in the evaluation of breast disease when combined with both physical examination and mammog-

raphy. But, it has been determined not to be an adequate screening method for breast cancer or other breast disease when used alone.

The Iowa Division, American Cancer Society, is conducting a cancer screening program in a several county area near Iowa City in cooperation with Creighton University. Approval for the project has been obtained from the involved county medical societies.

The Committee maintains in its file limited reference material to respond to physician inquiries which are received.

G. R. CLARK, M.D., *Chairman*

COMMITTEE ON ORGAN TRANSPLANTATION

The Committee on Organ Transplantation must report that its chairman has moved from Iowa to Texas. On December 1, 1976, Chairman Richard L. Lawton, M.D., became associate chairman of the Department of Surgery, School of Medicine, Texas Tech University, Lubbock, Texas. Part of Dr. Lawton's new assignment will be to establish an organ transplant program.

In the January issue of the *IMS JOURNAL*, an article co-authored by Dr. Lawton and John Davis, executive director of the Kidney Foundation of Iowa, discussed two new Iowa laws which have a relationship to organ transplantation.

One law allows a person to signal on his driver's license that he is a potential organ donor. This legislation was supported by the Society and the Kidney Foundation. The law became effective January 1, 1977, and is just now in the early stages of implementation. Space is provided on the license for affixing a decal signifying the donor's willingness to donate parts of the body upon death. If the licensee is so identified, he must also have on his person a organ donor card which "wills" his organs to a physician or an institutional beneficiary.

The new law pertaining to brain death does not become effective until January 1, 1978. The pertinent passage reads as follows:

Section 208. Death. "Death" means the condition determined by the following standard: A person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, that person has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of two physicians, based on ordinary standards of medical practice, that person has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

The article noted here provides an explanation of the brain death law and describes the impact and import of it to the organ transplant program. There has been some concern expressed over the need for an expressed opinion from two physicians.

It appears likely these new laws will have a salutary effect on the Iowa transplant program. Organ recovery has occurred in 10 Iowa cities since 1972 with the Iowa Transplant Service maintaining a 24-hour recovery team to respond to any donor situation. While the progress has been commendable, the number of transplant candidates (ranging from 50 to 120) far exceeds the availability of organs. Studies by the Kidney Foundation have indicated the number of brain deaths in Iowa surpass the number of transplant candidates. It is hoped the new laws will stimulate increased awareness and participation.

There are approximately 60 organ transplants being

done annually at the University of Iowa. It is believed between 85 and 100 could be handled using the basic facilities and personnel now present if the cadaver organs become available.

The Society was honored during the year by the Kidney Foundation of Iowa with the presentation of a plaque to a member of the IMS administrative staff. The liaison between the Society and the Foundation has been excellent.

PRECEPTORSHIP COMMITTEE

The IMS Preceptorship Committee continues to serve in an advisory capacity to the University of Iowa College of Medicine, and offers constructive suggestions regarding the implementation of Iowa's Preceptor Program and related projects.

In a recent conference with College of Medicine representatives, attention was called to an Education Newsletter published by the Association of American Medical Colleges. The publication contains an article concerning the increasing number of physicians entering primary care in Iowa, and the effect of the preceptorship program on this positive development. The article states that 31 persons completed primary care residencies (mainly family practice) in 1976, the first time the figure had been higher than the attrition rate of previous years (25). The U. of I. College of Medicine's preceptorship program was cited as a factor in the educational process which influenced this change. Established in 1952, with significant urging by and support from the IMS, the program was restructured in 1971 to direct students into primary care.

The article describes the progression for a student interested in primary care—i.e., participation in the MECO program (Medical Education Community Orientation), where post-freshmen students work during summers in community hospitals; the required primary care preceptorship in the junior year; an elective preceptorship in the senior year; and then residencies within the state in primary care.

In reference to the MECO program, although students do not receive curriculum credit, they are compensated for the services they perform. The project was established by the American Medical Student Association, and has had support and endorsement from the IMS.

The Committee has been apprised of a modification in the requirement for the third-year preceptorship—i.e., if a student desires to accept an out-of-state preceptorship, he must submit a written request stating specific reasons for preferring to work with a preceptor in another state. This information is provided to members of the College of Medicine Preceptor Committee for action. Few requests in this regard are received and, to date, one of three has been approved.

In response to recommendations offered by the IMS Committee a year ago, letters from the IMS president were mailed last spring to all physicians who served as preceptors expressing appreciation for their involvement in the program, and seeking their assistance in explaining to the students the importance of becoming active in organized medicine, with emphasis on locating in Iowa. Similar communications will be mailed on an annual basis.

The Committee has been advised that approximately 23 faculty members at the College of Medicine have taken part in the "Primary Care Preceptorship Program for Faculty" which was initiated over two years ago at the College of Medicine. Under the program, arrangements are made for interested faculty members to spend three days with practicing physicians in their offices; in turn,

the local physicians can elect to spend additional time with their faculty "preceptees" at the College of Medicine.

L. D. CARAWAY, M.D., *Chairman*

COMMITTEE ON QUACKERY

The Iowa Medical Society Committee on Quackery did not hold a formal meeting during the year primarily because most of the activity was legislative in nature. Individual members of the Committee continue to work with the IMS Committee on Legislation. As this report is written, Iowa chiropractors are at work at the Statehouse and are contacting legislators in their home communities. House File 256, "An Act Relating to the Practice of Chiropractic," sponsored by Representative Carl Nielsen of Altoona and 34 others, is presently assigned to the State Departments Committee of the House of Representatives.

This bill would broaden the chiropractic practice act and allow chiropractic "physicians" to draw blood for laboratory testing and otherwise perform many of the functions historically practiced by medicine. Proposed expansion also includes use of nutrition and diet management, and non-prescription drugs.

The following is an excerpt from a national health related publication (Popularity of chiropractic increasing):

(Chicago)—"Chiropractors are treating more patients than ever. They are licensed in all states, their colleges are gaining official accreditation from federal authorities and health care by chiropractors is being included in some insurance programs including Medicare and Medicaid." So reports the CHICAGO TRIBUNE. After years of attacks from the American Medical Association, some chiropractors have begun a counter-attack. An antitrust suit against the AMA and traditional medical foes of chiropractors has been filed in federal district court. The AMA has disbanded its Committee on Quackery, "and although it still opposes chiropractic, the opposition is less spirited." The reasons for chiropractic success: The emphasis chiropractors put on developing rapport with patients, the increased workload of medical doctors and the willingness of chiropractors to settle in areas spurned by M.D.'s, a "back to nature" movement among many people who prefer remedies other than surgery and drugs, and a general improvement in the educational background and image of chiropractors.

CLARENCE H. DENSER, JR., M.D., *Chairman*

COMMITTEE ON SPORTS MEDICINE

Members of the Committee on Sports Medicine have been involved individually in several sports-related activities during the year. The 1976 highlight for the Committee was the third in a series of every-other-year Conferences on the Medical Aspects of Sports. This was presented by the IMS and the Iowa High School Athletic Association on April 8, 1976, at the Iowa Methodist Medical Center in Des Moines. Approximately 150 coaches, physical education teachers, physicians and others attended this meeting. It is expected the Committee will meet in the summer and fall of 1977 to consider the continuation of this popular event in 1978.

The Committee was pleased to nominate and have selected the Iowa High School Athletic Association to receive the Iowa Medical Society Washington Freeman Peck Award in 1976. This recognition is given periodically to lay organizations which contribute significantly to the health and well being of the people. The award was presented at the 1976 IMS House of Delegates' Dinner with Committee representatives acting as hosts for Mr. Bernie

Saggau, executive secretary, and Mr. Dave Harty, assistant executive secretary of the IHSAA.

Several papers on sports-related subjects have been published in the JOURNAL OF THE IOWA MEDICAL SOCIETY this year. Articles by Peter Wirtz, M.D., a member of the Committee, have discussed (a) the important items to be kept in the "trainer's bag" along the sideline, and (b) the incidence of injuries sustained among players participating in the Iowa high school playoffs in 1975.

The Committee continues to be interested in the matter of weight as it pertains to wrestling competition. The position on weight loss in scholastic and collegiate wrestlers of the American College of Sports Medicine was made available to the Committee in 1976. This statement contains six recommendations to reduce potential health hazards created by procedures used to "make weight."

As suggested at the outset of this report, the Committee will soon become active in the consideration of a 1978 Sports Medicine Conference.

R. W. ANDERSON, M.D., *Chairman*

COMMITTEE ON VOLUNTARY HEALTH AGENCIES

The Committee on Voluntary Health Agencies continues to monitor information received from voluntary agencies such as the American Cancer Society, the Leukemia Society of America, Juvenile Diabetes Foundation, etc.; and pass along any pertinent information to members through IMS publications.

The Committee is pleased that a large number of Iowa physicians give freely of their time to serve these organizations directly or in the role of advisor.

There are periodic inquiries from the public seeking information about specific health related organizations. The AMA Directory of National Voluntary Health Organizations is utilized to answer these inquiries.

C. E. SCHROCK, M.D., *Chairman*

IMS AUXILIARY ADVISORY COMMITTEE

The main objectives of the Iowa Medical Society Auxiliary are: (1) To assist the Iowa Medical Society in the advancement of medicine and public health; (2) To coordinate and advise concerning the activities of constituent Auxiliaries; and (3) To cultivate friendly relations and promote mutual understanding among physicians' families.

The Advisory Committee to the Auxiliary reports that Iowa's organization for physicians' spouses continues active participation in and support of projects in its assigned areas. The Auxiliary members have cooperated with county medical societies and the state society in various programs, as their services were asked for or needed by the parent organization.

The main function of the AMA-ERF Committee is to raise money for medical education. The funds are turned over to the American Medical Association Education and Research Foundation and provide money for student loans and grants to medical schools. Money is raised by direct contributions, memorial contributions, fund-raising projects, and sales merchandising. The total contributions, to date, for half of the fiscal year are \$5,097.76.

Since May, 1976, emphasis has been placed on the importance of being informed and effectively lobbying for the AMA and the IMS through letters and conversations with state legislators. In addition to being advised as to the status of malpractice legislation at their annual meeting, a brief exercise in writing legislators was carried out. The same material, as well as suggested source material,

was sent to each member in September. The IMS Auxiliary is aware of pending legislation through articles in the IMS AUXILIARY NEWS and letters to the county chairmen. Efforts to aid the IMS have been encouraged by invitations to attend meetings of the Committee on Legislation and other programs of interest. The legislative chairman and two officers are now members of the IMPAC Board. A successful Legislative Brunch was hosted by the Auxiliary for the spouses of Iowa's lawmakers. A health related program on "Aging in the Year 2000" was presented by Woodrow Morris, Ph.D., U. of I. College of Medicine.

During this past year, members were included in a medical team of 35 doctors, dentists, nurses, and pharmacists traveling to Yucatan and Campeche. The State International Health Chairman received \$200 in donations from her speaking engagements and slide presentations. This money was used to send supplies to Yucatan. Polk County Auxiliary raised \$1,000 to be used by Promise unit in Yucatan for a washer and dryer. More technical help is needed for trips to Yucatan, such as lecturing in nursing, medical, and dental schools.

This past year the Auxiliary has requested Iowa auxiliaries to emphasize health education in their communities through the resources of the Project Bank. The Project Bank is a catalog of projects and programs compiled from all of the state Auxiliaries. This central source of information needs feeding constantly by those who can introduce new projects. The Project Bank has special opportunities waiting for members-at-large and county auxiliaries to help their communities become more active in health education ventures. Some of these helps are in the Package Programs. The Package Programs are designed by the AMA Auxiliary to stimulate ideas and give members background on subjects of interest to their communities. They establish educational programs, speakers' bureaus, hotlines, visual campaigns, and other specific and proven programs.

The Volunteer Health Service Award was again given to a lady for outstanding volunteer service. She was selected from several candidates by the Auxiliary's Advisory Committee.

The Auxiliary Newsletter is published and distributed to its members monthly. The Newsletter informs members of officers' activities, provides information on various county activities, and announces forthcoming plans.

A special Ad Hoc Planning Committee for Fifty-Year Program has been appointed by the president. This Committee will be responsible for planning the State Auxiliary's Fifty-Year Anniversary in May of 1979.

The IMS Auxiliary Advisory Committee will meet with officers of the Auxiliary prior to the Annual Meeting to consider any special activities and projects that might be of common interest and concern. The Committee urges IMS members to support the Auxiliary by encouraging 100% membership and solicits their assistance in the solution of any problem.

The Auxiliary is striving to overcome traits which have traditionally characterized women's groups, and make every effort to win recognition not only from the medical profession but from the lay public as well. Continuing growth on this basis is certain to enhance the image of the physician and the physician's wife through her work in the community and emphasize her serious concern in helping her physician-husband provide medical leadership for a better world through better health.

L. W. SWANSON, M.D., *Chairman*

This concludes the material published in the HANDBOOK FOR THE HOUSE OF DELEGATES.

Supplemental Reports

BOARD OF TRUSTEES

(A 10-minute slide presentation on the Iowa Medical Society preceded the first portion of this report.)

Section I—General Activities

Presented by J. H. Kelley, M.D.,
Member, Board of Trustees

(Referred to Reference Committee on Reports of Officers.)

Last May—in his first “President’s Message” published in the IMS JOURNAL—Dr. Jim Bishop told us for the coming year we had a “new name and a new face” for President; the year before it was Verne Schlaser, and next term it will be Bill Swanson. He also said: “It matters little who is president one year or another, but the Society itself matters greatly. It matters greatly that the Iowa Medical Society shall endure and grow in service, size, and strength.”

In this Supplemental Report, the Board of Trustees hopes to demonstrate to you that the Society is, in fact, enduring rather well, and is experiencing growth in size, service and strength.

SIZE

In a separate financial section, more specific information regarding our actual numbers will be presented to you. Suffice it to say now that insofar as membership is concerned, we have had our ups and downs.

Years ago, 95-98% of Iowa physicians were members of the IMS. This extremely high percentage was, in part, the result of a requirement that a physician had to belong to his county and state medical society in order to obtain hospital staff privileges. This, of course, is no longer true.

However, our membership record is a good one even without that requirement. Out of a potential 2,708 M.D.s in the state, we have 2,377 members. This represents approximately 88% of the M.D. population in the state, and an increase of 22 physicians over last year.

As the state’s physician population grows—and this is the trend—there will be increasing numbers of IMS members.

In response to a House of Delegates action last year, the Board of Trustees has given considerable attention to the matter of “unified membership”—i.e., a requirement that a physician belong to organized medicine at all levels (county/state/national) or none. In other words, a physician’s decision would be whether to join organized medicine; not what components of organized medicine he prefers to join. A specific recommendation in this regard will be submitted to you in the financial section of this report.

SERVICE

A primary function of the IMS is to serve both the profession and the public. Last fall, in conjunction with a very successful conference for county medical society presidents and other representatives, we attempted to determine just how well we were doing in the “service” area by conducting an informal, unscientific survey of physicians’ attitudes toward the Society, and their general

concerns about problems confronting the medical profession.

(At this time, copies of the Iowa Medical Society opinion poll were distributed to the delegates for their completion.)

As might be expected, members of the Executive Council—the Society’s interim policymaking body—ranked the IMS high in most areas of performance; non-members who were contacted thought we were doing rather poorly. County society presidents, however, gave high marks to the IMS in most all categories, particularly those of basic performance, legislative relations, professional liability activities, continuing medical education efforts, and involvement in health planning programs. We assume these leaders at the local level reflect the general thinking of their constituents.

We’d like to extend the scope of the survey today, and obtain the views of the members of this House of Delegates regarding the general performance level of the IMS, and the priority ranking delegates would give to some of our most pressing problems. A copy of the original survey questionnaire is included in your packets. Please complete it at your convenience, and either leave it at the IMS registration desk in the lobby—or mail it to the Society’s headquarters office after you have returned home. We’ll include a summary of the survey results in a future issue of the IMS UPDATE.

Over the years the Iowa Medical Society has demonstrated a willingness and an ability to assume leadership in various areas of activity crucial to assuring quality health care for the citizens of the state, and preserving for physicians a good private practice environment, and opportunity for a close doctor-patient relationship.

For example:

... the Society took an early leadership role many years ago in health planning activities by spearheading and financing the formation of the voluntary Health Planning Council of Iowa.

... the Society has long been in the forefront of peer review activity, and the physicians of Iowa have willingly engaged in voluntary programs to assure and enhance quality of care at a reasonable cost. Then, in 1971, anticipating the increasing amount of peer review responsibilities and governmental requirements, the Society formed the Iowa Foundation for Medical Care, which is now the Professional Standards Review Organization for Iowa.

... the Society has provided strong support for continuing medical education activities, via the IMS JOURNAL, which was recognized last year as an outstanding publication by the Sandoz Corporation, and the annual scientific sessions of the IMS, which afford physicians an opportunity to “learn and earn” since the programs are accredited for CME credits by the AMA and AAFP.

... the Society has supported efforts and programs designed to increase and improve the effective delivery of health care in the state, and has worked closely with the College of Medicine in this regard.

Perhaps some specific examples of more recent “service” to the profession and the public are in order at this point:

1. ASSURING QUALITY

Iowa Foundation for Medical Care: The IMS continues to maintain a strong liaison with the Iowa Foundation for Medical Care, and a report will be presented to you later this morning by the new president of that organization, Dr. John Brinkman of Mason City. In this regard, it is important for you to know that late in September members of the Board of Trustees met with officials of the IFMC to sign joint memorandums of understanding relating to (1) the establishment of a liaison committee for nomination purposes and general relationships between our two organizations; (2) IFMC responsibility for determining guidelines for health insurance reimbursement; and (3) the provision of administrative or consultative services by the IMS to the Foundation.

Board of Medical Examiners: Excellent communication has been established with the Board of Medical Examiners. If increased staffing and financial assistance become available, the Board has indicated a desire to become more active in dealing with complaints involving alleged incompetent or impaired physicians. Both the Board and the IMS, however, favor a "rehabilitative" course of action, rather than a "punitive" one, in dealing with matters of impairment and incompetency.

Continuing Medical Education: The Society and the Board of Medical Examiners have also consulted in regard to proposed legislation calling for continuing medical education requirements for the re-registration of a state medical license. Both the IMS and the BME support legislation currently under consideration which would require participation in continuing education, but only if it applies to all licensed professions and occupations, with each licensing board granted statutory authority to establish the requirements and the manner in which such a program would be implemented and administered. If and when such legislation is enacted, we are sure the BME will continue to confer with the IMS through our Committee on Medical Education and Hospitals.

In further reference to the Society's commitment to continuing medical education, you will recall that consistent with an action of the House, the IMS has been approved by the American Medical Association to survey and accredit institutions and organizations that develop and sponsor continuing medical education programs. Such accreditation recognizes that the institution meets certain criteria established by the IMS and AMA. Once accreditation has been granted, selected programs can then be designated by the institution for Category I credit toward the AMA Physician's Recognition Award.

In July of 1976 the first IMS-AMA Certificate of CME Accreditation was presented to Mercy Hospital of Des Moines. The Iowa Methodist Medical Center, Des Moines, received its CME accreditation just last month, and Iowa Heart Association will be awarded its CME accreditation certificate next month.

We were pleased that, after filing its first-year accreditation program report last March, the IMS was granted full approval as an accrediting body by the AMA for a period of four years.

2. ENHANCING THE EFFECTIVE DELIVERY OF HEALTH CARE

More Physicians for Iowa: The IMS and the University of Iowa College of Medicine maintain close ties, and the Society has encouraged and has been in full support of programs implemented by the College to train and retain increasing numbers of physicians for Iowa.

The community-based family physician resident train-

ing program has earned its "place in the sun." Fifteen of the 24 family practice residents who graduated last year are practicing in Iowa, 10 in towns of 9,000 or less population. The system continues to grow with seven approved Family Practice Residency Programs and 128 family physicians currently in training. The eighth residency program will begin in July.

The Medical Society has representation on the Family Practice Advisory Board which guides the program, and also works closely with the College of Medicine in the legislative halls in seeking appropriations to fund this and other valuable programs at the College of Medicine.

Alternate Delivery Systems: A special committee of the Society is available to consult with individuals and organizations interested in developing alternate delivery programs. This committee was extremely helpful to representatives of Blue Cross and Blue Shield and local physicians in setting up guidelines for establishing an HMO-type medical care delivery program based in Bloomfield for citizens of Davis County.

Physician Extenders: Several years ago, after learning that a physician's assistants bill was being introduced into the Iowa legislature, the IMS acted quickly in consulting with the sponsors, and recommended several significant and important changes to assure physician control over and responsibility for services provided by physician's assistants.

Many physicians have expressed genuine and justifiable concern about the present and future role of physician's assistants, and other physician extenders. It has been the position of the IMS to generally support the use of such personnel as long as the physician retains primary responsibility for patient care functions.

The IMS, through its Committee on Delivery of Health Services, has devoted a great deal of time and attention to this subject. It has met with representatives of the College of Medicine, which has a primary care Physician's Assistant Training Program; with representatives of the Board of Medical Examiners, which is responsible for the program in Iowa; and with Blue Cross/Blue Shield officials, who are concerned with reimbursement procedures for services provided by physician extenders.

An important report from the committee, including specific conclusions and recommendations regarding the function of physician extenders, is being submitted today for your consideration and action.

3. SERVICE TO THE PUBLIC

The IMS provides many services direct to the public—e.g., handling complaints via staff and Grievance Committee; responding to individual requests for health information; providing speakers and films to schools and lay organizations; cooperating with press, radio and television in the dissemination of health information, etc.

Indirectly, but most importantly, the public actually benefits from *all* of our efforts, especially in the areas of legislation, quality assurance, continuing medical education, delivery of health care projects, etc.

STRENGTH

The Iowa Medical Society is a strong, well-respected, and influential organization that is recognized as Iowa's "voice of medicine." As physicians and members of organized medicine, we gather together in our communities, counties, districts, and state to discuss issues that concern us professionally and as citizens. We never—or almost never—have complete unanimity of opinion. Through our democratic process, however, we do achieve a consensus,

and then set policies which chart a course of action for the IMS from one year to another.

Communications: Our strength depends in large part on knowledgeable and active members. Your officers and staff are diligent in their efforts to keep Iowa physicians well informed on current problems confronting the medical profession, and encouraging their active participation in helping to resolve them. To coin a phrase, "How do we do this? Let me tell you how!"

**New Member Seminars:* Each year new members of the Society are invited to attend a special informational conference at our headquarters building in West Des Moines.

**Fall Conference for County Medical Society Officers:* This conference is held at least every other year or oftener for the purpose of informing key medical society leaders about current issues and activities. At the conference that was held last October, we devoted a portion of the program to a "what flies your bic" session, and sought from the conferees their opinions and suggestions regarding ways in which the IMS can better serve the profession and the public.

**Visits to County Medical Societies:* For the past several years, the IMS President has made an effort to attend county medical society meetings over the state, and to visit formally and informally with physicians who are not actively involved in the work of the IMS even though they are members. Dr. Bishop visited with physicians in approximately 12 counties during the past year; other officers also had the opportunity to confer with their colleagues at the local level.

**Conference with Presidents of Medical Specialty Organizations:* Another annual event is the conference for presidents of medical specialty organizations in the state. This year we not only "talked at" these officers, we "listened to" them. It is obvious that no matter what specialty a physician practices, we all are experiencing similar problems in the legislative socio-economic arena; hence, a unified medical profession is essential if we are to preserve our traditional concepts of private practice, quality care, and high educational and ethical standards.

**Publications:* Each member of the Society receives on a regular monthly basis the IMS JOURNAL and a communication entitled IMS UPDATE that was initiated approximately one year ago. The UPDATE provides physicians with concise informational reports on various Society activities and current medical care developments in the state, and we have been pleased at the positive response to it. In addition, special UPDATE supplements are mailed to the membership on a need basis, as are Legislative Bulletins and other important messages to the membership.

Representing the Profession: Officers of the Society recognize the importance of constantly having "our hat in the ring." We strive to assure physician representation on important voluntary and governmental agencies concerned with health care matters, and we take the initiative in establishing liaison with groups that are involved in any way with health programs. Again, let me tell you how.

**Health Planning Activities:* At the beginning of this report, attention was called to our early leadership and participation in health planning activities. Our efforts in encouraging physician involvement in health planning at the local and state levels paid off when four M.D.'s were elected to serve on the 30-member Board of Directors of the Iowa Health Systems Agency, which was formed under provisions of P.L. 93-641. Not all states—in fact very few—are this fortunate. We know of one state that has an 80-member Board, with one physician on it!

John Tyrrell, M.D., of Manchester, a member of this House of Delegates, and an officer of the Society, serves as Vice President of the IHSA, and also was elected Vice Chairman of the State Health Coordinating Council, which functions under provisions of P.L. 93-641. Other doctors serving on the IHSA are Lawrence Ely, M.D., Des Moines, Russell Gerard, M.D., Waterloo, and Paul Seeborn, M.D., Iowa City.

**Professional Liability:* Two years ago there was a professional liability crisis in the state, and the phone was literally "ringing off the wall" with pleas from physicians to assist them in obtaining adequate coverage. The Society's Medico-Legal Committee, which had been involved in a study of professional liability problems and programs for some time, developed various legislative proposals designed to alleviate the problem in Iowa. Through many hours of consulting with legislative committees and subcommittees, and intensive lobbying efforts, some positive steps were taken to remedy a serious problem in the state that not only affected doctors, but their patients as well.

In recent months, the committee consulted with representatives of the Aetna Life and Casualty Company in developing a new IMS-sponsored insurance program for members of the Society. On March 9 details regarding the comprehensive liability insurance package available from the Aetna Company were mailed to all members of the Society. Specific details regarding this program will be presented to you in a report from C. H. Denser, M.D., Chairman of the Medico-Legal Committee. Dr. Denser and the members of his committee deserve our plaudits.

**Interprofessional Relations:* Over the years, the Society has been looked to for counsel and leadership from other health care provider groups. There has been dissension in the ranks at times, and not always do we and our allies agree on specific issues. Even so, the IMS recognizes the need for unity not only within the profession, but among the professions; hence, we endeavor to strengthen our communications and liaison with organizations that are involved in the delivery of health care.

One of our most successful recent projects was the co-sponsorship of a special conference by the IMS and Iowa Hospital Association. Over 200 physicians (including chiefs of hospital staffs and state and county society officers), hospital administrators, and hospital trustees attended the program. We were privileged to have James Sammons, M.D., Executive Vice President of the AMA, and Alex McMahon, President of the American Hospital Association, take very active roles in the conference. They, and other speakers, as well, spoke very earnestly and forthrightly about such matters as health care costs, assuring quality and competency, and relationships between the physician, the hospital administrator, and the hospital trustee. The program was very well received, and I am sure we will arrange another. Consideration will probably also be given to scheduling similar conferences with other provider groups.

**Blue Cross/Blue Shield:* The IMS has representation on the Board of Directors of both Blue Cross and Blue Shield. The Blue Shield Board is comprised primarily of physicians. Its members, as well as Mr. William Recknor, President, and Blue Shield staff, are receptive and responsive to recommendations and suggestions offered by the IMS, through its House of Delegates and Executive Council. For example, in response to actions of the House, the vast majority of Blue Shield contracts are based on the Usual, Customary, and Reasonable fee concept. Any contemplated major changes in contracts or new offerings are reviewed with the IMS prior to implementation. A

detailed report will be presented to you later this morning from Dr. E. E. Linder, Chairman of the Board.

Both Blue Shield and the Iowa Medical Society lost a good friend and an outstanding leader when Dr. Christian E. Radcliffe died last fall. Chris made outstanding contributions to Blue Shield, first as a director, then as President, and finally as Chairman of the Board. He also unselfishly gave his time and talents to the work of the Iowa Medical Society, and as an official representative of the Society he was an effective and influential member of the AMA House of Delegates.

**Cost Effectiveness Committee:* There is increasing concern over the rising costs of health care, and a special committee has been established by Blue Cross/Blue Shield to consider and develop ways to contain costs by implementing various cost effectiveness programs. The President of Blue Shield will comment on what developments have taken place.

**College of Medicine:* We are indeed fortunate in Iowa to have such an excellent "town and gown" relationship. Dr. John Eckstein, Dean of the University of Iowa College of Medicine, Dr. Paul Seeborn, Associate Executive Dean, and other administrative and faculty members, cooperate fully with the IMS on programs and projects of concern to the profession and the public. They are open and responsive to recommendations and suggestions from the IMS, and the officers of the Society attempt to be equally responsive to their concerns and ideas.

**Contacts with State Governmental Agencies:* Various committees of the Society consult on a somewhat regular basis with various agencies of state government. We have a good working relationship with the State Department of Health. Officials of the Department conferred frequently with representatives of the Society in the implementation of the swine flu immunization program.

Society representatives meet often with officials of the Department of Transportation. The Medical Advisory Board to the Department continues to provide a valuable and useful service.

I have already mentioned our close ties with the Board of Medical Examiners. I should add that we have also established a liaison with the State Board of Nursing as a result of our spearheading the formation of the joint M.D./R.N. Liaison Committee, which has representation from the IMS, Iowa Nurses' Association, and the medical and nursing boards.

Legislatively we have developed a very effective and successful lobbying system. Dr. Don Young, Chairman of the Society's Committee on Legislation, will report in more detail about our efforts in this regard.

We also have more than a nodding acquaintance with those at the "highest level of state government." And we are not reluctant to offer constructive recommendations and suggestions when appointments to important health-related boards or councils are to be made, or crucial decisions affecting medicine are to be handed down.

A recent action of the State Board of Pharmacy Examiners has demonstrated to your officers the need for developing an adequate mechanism by which the Iowa Administrative Code will be routinely reviewed, and any significant rules and regulations that might require attention and formal comment referred to appropriate officers or committees of the IMS.

The ruling of the Pharmacy Board which has caused some concern allows the Board to lift the license of any pharmacist who is employed by a physician; who leases space for a pharmacy on a "percentage of income" basis; or who pays rent that is not reasonable according to commonly accepted standards of the community. The Society has

kept interested physicians and clinic managers apprised of developments in this regard, and will provide whatever assistance it can in resolving any problems that might arise as a result of this action. However, it is not anticipated the Society will become directly or indirectly involved in any litigation that might result.

SUMMARY STATEMENT

We have not attempted to catalog all of our activities and concerns and interests; rather, we wanted to present to you in broad outline the ways in which the Iowa Medical Society serves the medical profession and the public.

In terms of size, service and strength, the IMS is a leader among leaders. We must continue to maintain a large, strong, and aggressive organization if we are to engage forcefully in the public debate that is deciding more and more medical issues.

SPECIAL RECOMMENDATION

Before introducing Dr. Havlik for a financial accounting from the Board of Trustees, I want to submit to you a recommendation from the Board regarding memorial recognition for deceased IMS members.

You will recall that Herman J. Smith, M.D., of Des Moines, who ably served the IMS in many capacities, including that of AMA Delegate, died last April. The 1976 IMS Merit Award was awarded posthumously to Dr. Smith at last year's Annual Banquet. In addition, the House responded to a resolution from the Polk County Medical Society by requesting the Board of Trustees, in consultation with officials of Polk County, to establish an appropriate memorial to honor Dr. Smith.

Representatives of the Board have met with officials of Polk County, and it was agreed that the following recommendation would satisfy the intent of PCMS to establish a memorial not only to Dr. Smith, but to other deserving physicians as well:

RECOMMENDATION:

1. That a special "recognition board" be purchased for placement in the IMS headquarters building. Brass plates will be attached to the board engraved with the names of deceased physicians to be selected by the Board of Trustees to receive special memorial recognition. The plate will also include the physician's year of birth and death. A larger brass plate will be affixed at the top of the board, appropriately inscribed with background information—e.g., "IMS Honor Roll—In Memoriam—The Iowa Medical Society pays special tribute to the following physicians who served with extraordinary dedication and distinction on various boards, councils, and committees of the Society to accomplish the basic objectives of organized medicine: 'to promote the science and art of medicine, and the betterment of public health.'"

2. The Board of Trustees will have responsibility for designating the physicians who should receive memorial recognition, and the effective date of such recognition (e.g., the physician should have been an officer of the Society, an active member of an IMS committee for a stipulated number of years, or have represented the Society in some other way).

If this recommendation is approved by the House of Delegates, the Board will take immediate steps to implement it.

Dr. A. J. Havlik, Chairman of the Board of Trustees, will present Part II of this report from the Board of Trustees on the subject of Finances . . . those important dollars that are necessary to underwrite the cost of the

many projects and activities of the Society that I have just outlined for you.

Section II—Finances

Presented by A. J. Havlik, M.D.,
Chairman, Board of Trustees

(Referred to Reference Committee on Reports of Officers.)

The 1976 House of Delegates, as it approved \$200 per member IMS dues for 1977, acknowledged that a dues increase would likely be necessary in 1978. The 1977 Budget, as a result of this delay in a dues increase until 1978, is in a deficit position based almost wholly on inflation, since Society staff and activities have been maintained at the existing level.

The 1976 House received a Board report which dealt with (1) the effects of inflation; (2) decreased staff; (3) decreased travel for both staff and officers; (4) membership efforts; (5) communications; (6) dues of other Iowa health organizations and other state medical societies; and (7) need for building repair and refurbishing.

All of these factors are still present and need to be evaluated as a dues increase for 1978 is considered.

1. Most experts are still predicting an inflation rate of 6 to 7 per cent or more in 1977 and beyond. Even a 5 per cent increased inflation factor would require from \$20,000 to \$25,000 additional funds each year to operate the Society at the present level. Since the last dues increase to \$200 per member was acted upon, the inflation factor alone has increased by 39% or \$78.

2. IMS staff has been maintained at 12 full-time persons. In addition, the IMS has 8 part-time staff, primarily the IMS/BS joint field force. The Board has agreed that additional staff needs to be employed to increase the IMS capabilities and effectiveness, particularly where the Society is representing the profession in matters of legislation, health planning, governmental programs and communications.

3. Authorized IMS travel continues to be held at a low level, but increased costs for all items of travel require higher expenditures. The number of regional and national conferences attended by IMS representatives is approximately one-half of those attended just a few years ago. The IMS sent representatives to only 10 out-of-state meetings in 1976. Five of these meetings were in Chicago and one in Minneapolis. Further limitations, in the judgment of your officers, would be counter-productive to the goal of the IMS being an active and involved medical organization.

4. IMS dues paying members have increased slightly in both 1975 and 1976. However, the number of eligible non-members also has increased. The Board has considered what effect "unified membership" might have on IMS membership. The Board believes that increased voluntary efforts to gain and retain members have been effective and, for the present, are preferable to a mandatory membership provision and therefore recommends that "unified membership" not be adopted. Individual counties may want to consider adopting a requirement that members of the county society also must join the IMS. This type of joint county-state membership requirement does exist in many states.

(Item No. 4 was referred to Reference Committee on Articles of Incorporation and By-Laws and Miscellaneous Business.)

5. The dues of other health organizations and other state medical societies have increased dramatically in the

past few years. Eighteen state societies have dues the same or higher than Iowa. Twenty-one state societies have had special assessments in 1976 and 1977, with several having assessments in both years. The IMS in 1975 was authorized to assess each member \$100 for expenses relating to professional liability matters, but the Board elected not to implement that authority. Twenty-five state societies have greater dues income than Iowa. Of the 12 state societies with membership from 1,700 to 3,000, Iowa falls slightly below the middle in the level of dues per member. Two of our neighboring state societies of greater size both have dues higher than Iowa—Wisconsin, \$300, and Minnesota, \$225.

6. A professional evaluation of building needs has been conducted, and a report is being analyzed to establish priorities for repairs and refurbishing. This will require an outlay of several thousands of dollars over the next few years.

7. Although the IMS has no outstanding financial obligations, cash reserve is only \$35,000. Many organizations attempt to carry reserve of 50-60% of yearly operating budget. This would require reserve of \$220,000 to \$265,000 for the IMS.

The Board of Trustees has considered several dues options. Dues increases of \$25 per member and \$50 per member were evaluated, but neither would provide sufficient funds to accomplish the financial goals which are essential, i.e., (a) permit staff expansion; (b) provide funds for building repair and refurbishing; and (c) provide additional reserve funds.

In addition, if either a \$25 or \$50 per member dues increase were adopted, the Board would, no doubt, be in a position of coming back to the House of Delegates next year recommending a further dues increase.

The Board discussed a \$75 per member dues increase and a \$100 per member dues increase effective in 1978. Although a \$100 per member dues increase would provide more flexibility in meeting the financial goals established by the Board and House of Delegates, the Trustees agreed that a \$75 per member dues increase would be sufficient and more completely acceptable to the membership. Such a level of dues increase should provide funds to operate the IMS on a sound financial basis for the next few years.

Based on all of the factors outlined in this report, the IMS Board of Trustees recommends that the IMS dues be established at \$275 per member for the year 1978.

The Iowa Medical Society maintains close contact with the Iowa Foundation for Medical Care, and it is a pleasure to introduce its new president, Dr. John Brinkman, Mason City, who will provide an update on PSRO developments and other activities of the organization.

REPORT TO IMS HOUSE OF DELEGATES IOWA FOUNDATION FOR MEDICAL CARE

J. H. Brinkman, M.D., President

(Referred to Reference Committee on Legislation and Medical Service.)

It is a pleasure to present this, our sixth annual report, to the Iowa Medical Society House of Delegates. I bring with me the best wishes of the Board of the Iowa Foundation to the delegates of this House.

I am pleased to present a report which demonstrates substantial progress by the IFMC in meeting its principal purpose and objectives as set forth by this House. My report will highlight some of the major areas of activity. A more detailed summary of peer review work is contained in your packet.

PSRO

The first area of activity I would like to address is our progress as a Professional Standards Review Organization. The IFMC has been functioning as a conditional PSRO for 16 months. Our task has been a large one, but we are pleased with the amount of work which has been accomplished.

We are, by hospital count, the largest conditional PSRO yet designated. Our area jurisdiction is statewide, which means we must establish working relationships with all 134 acute care institutions in Iowa. Thus far, the IFMC has entered into memorandums of understanding with 40 hospitals. These hospitals represent approximately 60 per cent of the inpatient admissions in the state. It is our intent to have all hospitals involved in PSRO review by the end of the year.

All hospitals signing memorandums of understanding to date have met the IFMC's criteria for performing delegated review. This means they have demonstrated capabilities to perform review locally and make binding review decisions on the intermediary. The IFMC will monitor these hospitals to assure continued effectiveness and to assess the value of the type of review required by the PSRO law.

We recognize that all hospitals will not be able to meet all the criteria for performing delegated review. Some hospitals will need to function with the IFMC on a non-delegated basis. This means we will provide the personnel to perform the review. This type of relationship should not be viewed negatively. It is our hope that many hospitals will consider this an interim step before achieving delegation. The IFMC will provide as much technical assistance as possible to help a hospital or group of hospitals

obtain delegation. During the past few weeks IFMC staff has visited all hospitals to assess the level of activity and determine the need for assistance.

A primary objective of the IFMC has been to utilize the results of peer review and medical audit in determining continuing medical education needs. It has been the assignment of Dr. Richard Caplan and the Continuing Medical Education Committee to develop this aspect of our program. The committee has met once to discuss guidelines and set forth a topic which can be used in conducting an areawide medical audit. The topic they have selected is pneumonia. Although delegated and non-delegated hospitals will be required to participate in the areawide audit, all hospitals are encouraged and invited to participate.

PRIVATE REVIEW

Another area of IFMC activity is the review of patients covered by private and commercial health insurance carriers. We have recently completed agreements with Blue Cross and Deere and Company for the performance of hospital review. In the near future, we plan to reach an agreement with the Health Insurance Association of America, which represents all of the commercial health insurance companies doing business in the state.

It has been the intent of the IFMC not to segregate its review by insurance carrier. Many hospitals are already performing all-patient review. It is our desire to provide the same guarantees to these hospitals in performance of their review as we are to the government in performance of PSRO activities.

We feel the entry of the Foundation into private review is a very positive step in our growth. The need for assuring appropriateness and quality of care will be carried

PEER REVIEW REPORT 1976

	<i>First Quarter Cases</i>	<i>Second Quarter Cases</i>	<i>Third Quarter Cases</i>	<i>Fourth Quarter Cases</i>	<i>Total</i>
FIRST LEVEL REVIEW					
Prior Pending (December 31, 1975)					109
Submitted	247	151	189	123	710
Resolved	156	214	149	147	666
Withdrawn	5	—	1	3	9
PENDING CASES AS OF DECEMBER 31, 1976					144
FULL COMMITTEE REVIEW					
Prior Pending (December 31, 1975)					7
Submitted					
(carrier)	5	—	—	—	5
(physician)	16	4	2	5	27
Resolved	—	14	3	6	23
Withdrawn	—	—	1	—	1
PENDING CASES AS OF DECEMBER 31, 1976					15
BOARD OF DIRECTORS					
Prior Pending (December 31, 1975)					5
Submitted					
(carrier)	3	—	2	3	8
(physician)	—	—	5	—	5
Resolved	7	1	—	2	10
Withdrawn	—	—	—	—	—
PENDING CASES AS OF DECEMBER 31, 1976					8

over to private patients. But most importantly, we are free of the standardization which comes with review performed under federal regulation.

Our plan for implementing private review will be essentially to build on to the existing PSRO review system. Existing memorandums of understanding will be amended to provide for the additional review of private patients. Our understanding with the health insurance company provides the same guarantees to the hospital for binding review decisions as exist with PSRO. The insurance companies will accept hospital review decisions for payment if their review system has been approved by the IFMC.

FEE REVIEW

We have continued to perform peer review for physicians, patients, and insurance carriers. During 1976, the IFMC resolved over 600 cases through the peer review process. Though this is a decrease from the previous year's case load, it is significant that we are working closely with physicians and carriers to peer review only those cases that truly need review. We have observed again this year an increase in the number of physicians who are initiating requests for peer review. Twenty per cent of the cases received last year were requested for review by physicians. This review was accomplished at no cost to physicians but at an approximate cost of \$15,000 to the IFMC. The IFMC also continues to work closely with most of the major commercial and private carriers in the state.

The IMS House of Delegates last year adopted a resolution which provided the IFMC with authority to develop guidelines with health insurance companies in the state. As a result of this, the IFMC initiated a review of past guidelines. This analysis began by a survey of all peer review committee members. A new set of guidelines was then developed by the Committee on Peer Review. Guidelines were then submitted to the subcommittee on medical review (a joint committee of the IMS and IFMC). Additional recommendations were drawn up and submitted to the IFMC Board for its review and adoption. Guidelines were adopted at the IFMC's April Board meeting. Guidelines are presented in your packet of materials for information. Also enclosed in your packet is a statistical summary of peer review activities last year.

ORGANIZATIONAL ACTIVITIES

The IFMC Board recently adopted a resolution to expand Board membership to others concerned with the activities of peer review. The IFMC will present for ratification of the membership the provisions for adding a hospital administrator, a nursing home administrator, a dentist, and a podiatrist. The IFMC works very closely with other providers in carrying out its activities as a PSRO. These members have sat with the IFMC Board for almost two years in an advisory capacity. Their addition to the Board will enhance the input and association with the IFMC through their respective organized bodies.

The Board also adopted a provision for placing a representative from management and a representative from labor on the Board. The concern with health care costs and quality being heard from these two segments of the community is the reason for providing membership to these individuals. We feel our efforts in peer review are not generally known throughout the community.

LONG-TERM CARE REVIEW

The IFMC has been studying the possibility of becoming involved in the review of intermediate care facilities.

This has come about through a request from the State Department of Social Services. An ad hoc committee of the IFMC has been considering all aspects of our involvement in the review of long-term care. Currently our discussions with the State have been suspended pending the settlement of the matching rate from the Department of HEW for performing this review.

RELATIONSHIP WITH THE IOWA MEDICAL SOCIETY

In closing, I would like to say we continue to work very closely with the Iowa Medical Society Executive Council and Board of Trustees. Reports on IFMC activities are provided to the Executive Council at its quarterly meetings. In addition, we consult with the Board on matters of policy. We will continue to relate very closely to the IMS as we implement new programs and procedures.

IFMC DELEGATED IMPLEMENTED HOSPITALS

JENNIE EDMUNDSON, Council Bluffs
 SCHOITZ MEMORIAL, Waterloo
 ST. JOSEPH, Ottumwa
 ST. LUKE'S, Cedar Rapids
 BURLINGTON MEDICAL CENTER, Burlington
 OTTUMWA HOSPITAL, Ottumwa
 MERCY HOSPITAL, Cedar Rapids
 TRINITY REGIONAL, Fort Dodge
 CASS COUNTY, Atlantic
 ST. JOSEPH MERCY, Clinton
 MARY GREELEY MEMORIAL, Ames
 JANE LAMB, Clinton
 HUMBOLDT COUNTY, Humboldt
 ST. JOSEPH'S COMMUNITY, New Hampton
 PELLA HOSPITAL, Pella
 ST. VINCENT'S, Sioux City
 ALLEN MEMORIAL, Waterloo
 MERCY, Des Moines
 MERCY, Iowa City
 IOWA METHODIST, Des Moines
 SARTORI, Cedar Falls
 ST. LUKE'S, Sioux City
 MERCY, Dubuque
 ST. JOSEPH MERCY, Mason City
 BOONE COUNTY, Boone
 ST. LUKE'S, Davenport
 MERCY, Davenport
 WINNESHIEK COUNTY, Winneshiek
 IOWA LUTHERAN, Des Moines
 DALLAS COUNTY, Perry
 NORTH IOWA MEDICAL CENTER, Mason City
 MAHASKA COUNTY, Oskaloosa
 UNIVERSITY HOSPITALS & CLINICS, Iowa City

Listed below are the statistics compiled from the Delegated Hospitals for the first quarter of 1977:

<i>Total Discharges</i>	<i>Admission Reviews</i>
10,554	10,040
<i>Continued Stay Reviews</i>	<i>Total Days of Stay</i>
9,680	94,312

IFMC FEE REVIEW GUIDELINES
EFFECTIVE DATE: APRIL, 1977

I. UCR

A. All fee review recommendations for private and self-insured groups will be made based on the usual, customary, or a reasonable charge of a physician's service as defined below.

1. The *usual* charge is the most consistent charge made by an individual physician to patients for a given procedure.

2. The *customary* charge is the 90th percentile of the range of statewide charges for a given service billed by physicians with similar training and experience.

3. A *reasonable* charge infers that a charge is reasonable when, in the opinion of medical review, it merits special consideration based on complexity of treatment.

B. Federal programs, Medicare and Medicaid, utilize a different set of definitions for the allowances possible. Fee review of Federal cases will be based on these definitions.

1. The individual physician's charge for a given service is referred to as the *customary* charge.

2. The area range of submitted charges is called the *prevailing*. Eight areas in Iowa are used to compute eight prevailing charges. Under certain circumstances, a statewide prevailing is assessed by Medicare.

C. For continuity of review and profile development, the IFMC Committee on Peer Review endorses and encourages the use of the AMA-developed CPT coding system for the assigning of procedure codes for the medical service rendered.

II. SURGICAL SERVICES

A. A total surgical allowance includes surgery, usual pre- and post-operative care, and any routine hospital visits and consultations by the surgeon.

B. Hospital admissions, as well as specific procedures provided which are not considered within the normal pre- and post-operative care, will be considered as reimbursable.

C. A physician who assists at a surgical procedure should be encouraged to always charge his *usual* charge to permit the construction of credible assisting surgeon profile data. In lieu of valid customary data, up to 25 percent of the surgical fees or an hourly rate may be allowed. Peer review will recommend allowance for assisting, independent of the surgeon's charge except in those procedures determined not to require an assistant.

D. In instances of two or more operations performed by the same surgeon to treat independent surgical indications through the same operative incision (including bilateral procedures), a charge of 100 percent for the primary procedure and 25 to 50 percent for the secondary procedure may be recommended. The application of this range would be dependent upon the complexity of the procedures performed. In the instance of separate surgical procedures performed by one surgeon through separate incisions, a charge of 100 percent for the primary (most critical) procedure and 50 percent for the secondary may be recommended. Special consideration will be given to complex surgical procedures which may warrant additional allowances.

E. Incidental surgical procedures, such as incidental appendectomies, will not be recommended as compensable.

F. When two physicians of different disciplines perform independent procedures concurrently under the same anesthesia, both charges may be considered at 100 percent.

III. CONSULTATIONS

A. A consultation is considered to include those services ren-

dered by a physician whose opinion or advice is requested by another physician or agency in the evaluation and/or treatment of a patient's illness. A consultation will be recommended as one of the following:

1. *CPT #90600 Consultations requiring limited examination and/or evaluation of a given system but not requiring comprehensive history and examination, home office, or hospital.

2. *CPT #90610 Consultation requiring more extensive examination and/or evaluation but not requiring comprehensive history and examination, home office or hospital.

3. *CPT #90620 Consultation requiring comprehensive history and examination and/or evaluation, home office or hospital.

4. *CPT #90630 Consultation of unusual complexity exceeding scope of services identified by 90600, 90610, or 90620, necessitating history and examination, extensive review of prior medical records, compilation of diagnostic material, and the preparation of a special report, home office or hospital.

B. If the type of consultation is not indicated in billing, it will be recommended as a limited consultation.

C. The service of consultation may be a distinct service when performed prior to surgery. However, when a consultation by a surgeon results in surgical services and the consultation is not part of the normal pre- and post-operative care, it is compensable.

IV. INTENSIVE CARE

There are normally two ways of billing for intensive care in the hospital. The first is when a physician visits his patient in the intensive care unit or the coronary care unit of the hospital. The second method is used when actual intensive care is rendered by the physician, whether in the intensive care unit or not. On intensive care cases, it is essential that the actual time spent with the patient be documented.

V. CONCURRENT CARE

Unrelated concurrent care can be considered when, because of necessity for supplemental skills, two or more physicians treat a patient for two or more *separate* and *distinct* conditions. It may consist of hospitalized medical care, surgery, and/or radiation therapy.

(Resumption of the report by Dr. Havlik.)

An excellent relationship exists between the Iowa Medical Society and Blue Shield. It is the result, in part at least, of a close working relationship between the officers and staffs of the two organizations. On April 13 the Board of Trustees met in joint session with the Executive Committee of the Blue Shield Board of Directors to discuss several matters of current concern. I am sure these will be reported to you by Dr. E. E. Linder, Chairman of the Blue Shield Board of Directors.

BLUE SHIELD OF IOWA REPORT TO IMS HOUSE OF DELEGATES

Enfred E. Linder, M.D.,
Chairman, Blue Shield of Iowa Board of Directors

(Referred to Reference Committee on Legislation and Medical Service.)

The survival of any institution or organization is dependent upon its ability to anticipate and react to change. This is just as true for Blue Shield of Iowa as it is for any other business. Currently, there are trends in the health care field that appear to forecast the need to re-examine our policies, philosophies, goals and activities with an eye toward change.

The one trend that is having the greatest impact on the

health field today is consumerism. At Blue Shield of Iowa, we are experiencing that impact in three areas: board representation, cost effectiveness, and utilization of health care services.

The increasing activism of consumers and the Federal Trade Commission's protection of consumer rights affect every institution or business that provides a service or a product to the public. Consumers want the right to have a say in anything that involves them. Blue Cross and Blue Shield of Iowa officially recognized the importance of the consumers' movement with the 1974 formation of 12 Subscriber Advisory Committees. But there are new aspects to the consumers' movement, and the pressure we are receiving is for more lay representation on the Blue Shield Board of Directors. The subscribers believe that decisions affecting their health costs should not be decided by a board dominated by physicians but by a board with a fair proportion of lay representation. This movement is not restricted to Iowa. Instead, Blue Shield Plans across the country are reacting to the growing demand for subscriber and consumer representation on governing bodies.

Cost is an area that is concerning our individual subscribers as well as the industries and businesses that offer health coverage as an employee benefit. This year we are finding that some subscribers can no longer afford our coverage. They elect instead to go "bare," to take their chances with illness and medical catastrophes just as some physicians have elected to do without malpractice insurance. This lack of health coverage alarms us since we can anticipate the effect it would have on the physicians as well as the whole health care delivery system if it became widespread.

The Blue Shield Plan's UCR coverage is considered the best and most comprehensive policy for medical services. But the rising costs of health care may make it necessary for us to develop a less comprehensive, more affordable policy for those subscribers and employers who can no longer pay for the best.

The entire health care system is dealing with the problem of cost. During 1976 the joint boards of Blue Cross and Blue Shield of Iowa established the Iowa Cost Effectiveness Committee. They sought and obtained representation from the Iowa Medical Society, Iowa Hospital Association, Iowa Medical Foundation and the Iowa-South Dakota Hospital Advisory Committee. The broad representation reflects the Blue Shield belief that the voluntary health system has the ability and the challenge to deal with the problem of costs voluntarily.

The final consumer area in which we have noticed an impact is that of incidence of use of both physicians' services and hospitalization. This increased incidence has a direct bearing on the rising cost of coverage, but in this instance it is we who must pressure the consumer. We assume that the increased utilization of medical services stems from the lifestyles of our subscribers. People are not accepting the responsibility for their own good health and their own well being. Instead they over-eat, ignore the basics of good nutrition, smoke too much, over-indulge in alcohol or stimulants, under-exercise, and expose themselves repeatedly to stressful situations.

To meet this situation, Blue Shield and Blue Cross of Iowa are examining their place in the field of health education and are working on developing a health plan that will motivate our subscribers to assume more responsibility for their own good health.

All of Blue Cross and Blue Shield of Iowa's activities in 1976 reflect our awareness of the need for cost effectiveness. We continued to experience success in our alternate delivery systems.

Patient Assessment and Diagnostic Evaluation is a program which was developed in cooperation with the medical staff and Mercy Hospital in Des Moines in 1975. Its purpose is to determine a patient's illness and prescribe a course of treatment as an outpatient instead of as a bed patient. The program is designed to reduce the number of hospital admissions and covers the costs of diagnostic X-ray and laboratory procedures as well as the physician's fee for professional diagnosis. During 1976 the PADE program saved 1,051 inpatient days at Mercy, and the number of patients using the program increased from 15 to 94 per month during the year. So far in 1977, the number of patients using this program has risen to 100 per month.

Pre-admission testing is also designed to save hospital days by allowing patients who are scheduled for surgical hospital admission to receive their laboratory and other tests as outpatients before being admitted for bed care. Sixteen new hospitals joined this program in 1976, increasing the total number of participating hospitals to 51.

One-Day Surgical Care is another program that holds promise for substantial savings. The program was initiated at Mary Greely Hospital last year. It allows patients who are scheduled for certain surgical procedures to take their preliminary X-ray and laboratory tests on an outpatient basis. On the day their surgery is scheduled, the patients check into the hospital early in the morning, undergo surgery, and are discharged in the afternoon. This eliminates the cost of admitting the patients for regular hospital bed care and the cost of staffing the unit around the clock.

This past year, Blue Cross and Blue Shield of Iowa participated in the establishment of Central Iowa Medical Surgical Associates. This is a joint venture between seven Centerville physicians and 21 referral physicians in Des Moines who are either Board eligible or Board certified. The system forms a communications link between the two physician groups that is expected to improve the delivery and accessibility of health care in the Centerville area, assist in the continuing education of the rural physicians and reduce the out-of-pocket costs to the patients.

Rural Health Services completed its first year of operation during 1976. RHS has been well accepted by the physicians and the 3600 Iowans enrolled in the program. In January, 1977 it became necessary to increase premiums to offset losses incurred during the first year of operation. We are continuing to make additional changes and improvements in the program to assure its success.

Last year we reported on our conversion to CPT coding system which took place in March 1975. During 1977 Blue Shield of Iowa will implement a recently modified version of CPT-4 for reporting physicians' services. Currently 67 per cent of all claims for private Blue Shield business is now pre-coded.

As requested by this House of Delegates, Blue Shield of Iowa has continued to provide the Usual, Customary, and Reasonable contract to its subscribers. At present, almost 95 per cent of our subscribers under age 65 are enrolled under the UCR contract, and almost 90 per cent of all claims come from participating physicians.

Blue Shield of Iowa is aware of the interest of physicians, medical assistants and subscribers in the UCR contract. Many questions are raised about the allowances, contract benefits, responsibilities of the Blue Shield participating doctors, our responsibilities to the physicians and the IMS involvement in the UCR contract.

In conjunction with the Iowa Medical Society, Blue Shield has a responsibility to continue to up-date information for the medical community and our subscribers

about the UCR contract. To help accomplish this, we recently prepared two brochures on the subject, one for physicians and another informing subscribers of "Ten Things You Should Know About UCR."

Later this month members of the IMS/Blue Shield professional relations staff will begin a program designed to inform Iowa physicians about the UCR contract and the advantages and responsibilities of participating physicians. The professional relations representatives will be contacting you and your office staffs to discuss the UCR contract and its provisions.

We have also begun discussions with physicians' offices and service bureaus to permit physicians with sufficient claims volume to submit tape-to-tape claims. Computer programs have been written for this process which results in more efficient administration and a reduction of cost and paper work. Physicians interested in an automated claims system may contact our professional relations representatives.

The year 1976 brought continued growth in Blue Shield of Iowa's enrollment, in claims processed, in benefits paid, and in managerial skill.

We processed more than \$145.7 million in benefits for our own members and for beneficiaries of government health care programs; Blue Shield of Iowa dispersed \$97.6 million in benefits for 1.8 million claims. Including Major Medical payments, Blue Shield of Iowa paid out over \$105.9 million for claims. This represents an increase of \$16 million over 1975's total.

In addition to payments made for claims incurred under our regular lines of business, another \$37.6 million was dispersed for services provided under the Medicaid program and one million dollars under the CHAMPUS program for military personnel.

The number of Iowans enrolled in the Blue Shield Plan increased by 34,213 members in 1976, bringing our total enrollment to 1,270,499 or 43 percent of the state's population. When the participants in government programs are added to private business participants, Blue Shield of Iowa serves approximately 1.7 million people, or 54 percent of all Iowans.

Blue Cross and Blue Shield of Iowa achieved more efficient and cost effective management in 1976. Through the use of a scheduling system, the corporations saved \$435,000 in spite of a 17 per cent increase in the volume of work. The system allowed a further savings by reducing the need for overtime and part-time employees. Last year the administrative cost per dollar of all claims paid for all lines of business was only 5.25¢ compared to 5.78¢ the previous year.

Blue Shield of Iowa owes its success to the cooperation it receives from the physicians of Iowa, the dedication and direction of its Board of Directors, its management and its employees. Without the continuous efforts of all of these groups and without the strong leadership of Bill Recknor, no success would be possible. Our success also depends on retaining the close working relationship we enjoy with the Board of Directors of Blue Cross of Iowa and President Dave Neugent. As well, we'd like to acknowledge the cooperation we receive from Don Happe and Blue Cross of Western Iowa.

We were saddened by the death of Dr. C. E. Radcliffe who served as the Board Chairman of Blue Shield and who delivered this report last year. Dr. Radcliffe was one of Iowa's pioneers in prepaid health care. He is missed on Blue Shield's board and I know that he is missed by the physicians here today.

Blue Shield of Iowa's goal is to deliver the best possible health care plan to the people of Iowa at the least possible

cost. That goal could never be reached without the cooperation, conscientiousness and commitment of the physicians of this state. On behalf of the subscribers who profit through your commitment, the Board of Directors who represent your conscientiousness and the Blue Shield staff who count on your cooperation . . . I extend appreciation to the House of Delegates and to all members of the Iowa Medical Society who support and contribute to Blue Shield of Iowa. With your continued support and understanding, we'll be able to deal with the coming changes that will permit us to become an even more relevant health resource for our subscribers and your patients.

(Resumption of the report by Dr. Havlik.)

This concludes the 1977 Supplemental Report of the Board of Trustees. We hope we have demonstrated that the officers, committees and staff of the IMS are diligent in their efforts to maintain the freedom of the physician to practice in a free environment, and to assure high quality medical care to all Iowans.

A. J. HAVLIK, M.D., *Chairman*
J. H. KELLEY, M.D.
HORMOZ RASSEKH, M.D.
J. F. BISHOP, M.D.
L. W. SWANSON, M.D.
A. W. BOONE, M.D.
W. R. BLISS, M.D.
T. A. BURCHAM, M.D.

At the conclusion of the report, Dr. Havlik presented a check for \$12,523.15 from the American Medical Association Education and Research Foundation to Dr. John Eckstein, Dean of U. of I. College of Medicine.

John W. Eckstein, M.D.,
Dean, University of Iowa College of Medicine

Mr. Speaker, officers, members of the House, and guests: It is a pleasure to come here each year to get this check. I know how much work is done by those who raise money for AMA-ERF, and we appreciate it very much.

I'm usually given an opportunity to say a few words to the House of Delegates. Dr. Bishop extended that invitation again this year. The Speaker said he didn't want to hear that nonsense again, so I will spare you an address.

I do want to say a couple of words because I was quite moved by Dr. Palmer's address to you.

I think if I were to prepare a talk and I were to list the intrusions of government into the area of medical education and medical schools, virtually everything on that list that was discussed by Dr. Palmer would be on my list.

I think we in the medical schools will feel some of these things earlier than the practicing physicians. I think that nine per cent cap, if it comes about, is going to be much more difficult for teaching hospitals, particularly university state-owned teaching hospitals, to cope with. I think that when fee regulation, federal regulation of professional fees, comes about, it can be done very directly and very quickly in teaching hospitals.

What I'm trying to say is that we all face the same kinds of problems. The only thing that Dr. Palmer did not mention, which I would regard as an intrusion—and I'm sure he would have mentioned it and would agree—is the health manpower legislation which has to do with federal support of medical education and the quid pro quos that are demanded of the medical schools in order to get the federal funds without which we cannot live.

So there are many problems, we are in it together. The American Medical Association House of Delegates last

December approved the formation of a new section which will be a section on medical schools, and we will have a delegate on the floor of the House in the AMA, eventually. We think this is fine.

I was invited to participate in conferences with members of the Board of Trustees and members of the Council on Medical Education in discussions before the proposal for that section was presented to the House, and I think it is important that the medical schools be represented.

We all graduated from medical schools, and medical schools do have a major role in the affairs, I think, that physicians have. We think it is particularly timely because the interns and residents and students are well represented in various sections of the AMA, so we are pleased to have this opportunity, and if everything goes well, we may have a delegate in San Francisco.

I would like to say one final word or two about our associations with the Iowa Medical Society. As you all know, members of our faculty interact on many of the Iowa Medical Society committees. We interact in many, many ways in ad hoc situations, and we treasure those interactions. They are going to be more and more important as time goes on, as these increased numbers of intrusions come to us, and we very much want to work with the Medical Society in the future as we have in the past.

I want to thank the officers and leadership of the Medical Society for the many courtesies that we have had from them during the past year, and I particularly want to thank the staff, as I always do, because I have said many times that a call to the Iowa Medical Society office usually brings information faster and more efficiently than any other office, I believe, that we deal with.

Thank you again for giving me the opportunity to be here.

INFORMATIONAL REPORT ON THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY

Presented by Hormoz Rassekh, M.D.,
Member, Board of Trustees

The Scanlon Medical Foundation/Iowa Medical Society is fast approaching the twenty-fifth anniversary of its founding and in that time nearly 350 aspiring Iowans have been helped in the pursuit of their medical educations. The Foundation student loan program was begun in 1953 under the impetus of the late George H. Scanlon, M.D. It was known at the outset as the Iowa State Medical Society Educational Fund.

In a 24-year period, the Foundation has loaned \$623,409.52 to 340 medical students. To demonstrate the recent upsurge in the Foundation assistance program, close to \$300,000 in loans have been made since 1970. This active and tangible support of medical education in Iowa is significant and worthy of notation.

The following statistical highlights are current and submitted for the record:

1. There are 29 Iowans receiving medical student loans this 1976-77 academic year. The names of the current recipients, their hometowns and their classes accompany this report.

2. The actual amount of money loaned between 4/1/76 and 4/1/77 is \$43,110. The amount of money repaid in principal and interest during this period by loan recipients in practice totals \$17,815.42.

3. The amount of loan money outstanding as of 4/1/77 was \$332,483.24. Of the amount loaned since the inception of the program (\$623,409.52), the amount repaid as of 4/1/77 totaled \$290,926.28.

SCANLON MEDICAL FOUNDATION/ IOWA MEDICAL SOCIETY 1976-77 STUDENT LOAN PARTICIPANTS

STUDENT	HOMETOWN	FR.	SOPH.	JR.	SR.
Bast, Kelly Scott	Urbandale			X	
Beach, Dennis Randall	Davenport		X		
Blew, Stanley A.	Ottumwa			X	
Bratkiewicz, Richard S.	Sioux City		X		
Brown, David L.	Charles City				X
Cranberg, Lee D.	Des Moines			X	
Drake, Robert Lewis	Brooklyn			X	
Eischeid, Wanda	Halbur	X			
Falcon, Jennings II	Cedar Rapids			X	
Faylor, James	Missouri Valley			X	
Fisher-Beckfield, Paul	Storm Lake				X
Gacke, Jerome Thomas	Rock Rapids		X		
Iverson, Nancy	Ottumwa			X	
Koehler, Richard	Washington			X	
Lasche, John Francis, Jr.	Ames	X			
Leonard, Sharleen	Holstein			X	
McAllister, Janice	Atlantic			X	
Nuss, Frederick S.	Waverly			X	
Pfeffer, John Charles	Cedar Rapids			X	
Quigg, Gary R.	Davenport			X	
Quinlan, Wm. J.	Des Moines			X	
Reif, Maryellen	Clinton			X	
Roepke, Kenneth R.	Sioux City			X	
Rogers, John J.	Davenport			X	
Welsh, Stephen	Emmetsburg		X		
Whalen, Johanna Bonde	Elkader				X
Woster, Allen Dennis	McCallsburg				X
Zeitler, Rodney R.	Douds			X	
Zurbruggen, Thomas	Elgin			X	

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY Income and Expense Statement—December 31, 1976

INCOME:	
Contributions and Memorials	\$25,662.87
Henry Albert Trust	10,086.02
Interest on Loans	2,040.76
Interest on CNB Golden Passbook Savings	2,388.22
The Prouty Company	375.00
Student Nursing Loan Acquisition	27,978.92
Student Nursing Loan Repayment	543.71
Miscellaneous Income	275.00
Total Income	\$69,350.50
EXPENSES:	
Public Service Projects	
Iowa Blood Council	\$ 200.00
Hawkeye Science Fair	4,900.00
Medical Education Projects	
Monthly Scientific Articles in	
IMS JOURNAL	2,000.00
Iowa Chapter, Student AMA	750.00
Baldridge-Beye Lecture (IMS	
Scientific Meeting)	284.77
Health Research Projects	
Employment of the Handicapped—	
Essay Awards	131.25
Administrative	
Iowa State Bank & Trust Company	400.00
Interest Paid on Loans from Physicians	1,000.00
Student Nursing Loans	3,925.00
1976 Consulting & Staff Services	5,000.00
Legal Services	1,404.50
Audit & Tax Return	150.00
Miscellaneous Administrative Expenses	124.96
Total Expenses	\$20,270.48
Net Gain for 1976	\$49,080.02

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY BALANCE SHEET—DECEMBER 31, 1976

ASSETS	
Iowa State Bank & Trust Company	\$ 1,209.90
Central National Bank & Trust Company	1,535.14
CNB Golden Passbook Savings	57,217.41
Notes Receivable from Medical Students	318,962.82
Student Nurse Loan Fund	3,701.63
Notes Receivable from Auxiliary Loan	
Recipients	16,488.97
Total Assets	\$339,115.87
LIABILITIES AND NET WORTH	
Notes Payable to Physicians &	
County Medical Societies	\$ 53,203.62
Net Worth:	
Balance 1-1-76	\$296,832.23
Add: Net Gain for 1976	49,080.02
Total Liabilities and Net Worth	\$345,912.25
	\$399,115.87

4. There have been loans made to 340 Iowans through the years and 175 have repaid their borrowings in full.

5. Total resources on loan to the Foundation from physicians, county medical societies, specialty organizations and the Iowa Medical Auxiliary is \$53,203.62.

The Scanlon Foundation has received additional support in 1976-77 through various contributions and memorials. The following are principal amounts received this past year:

1. The Henry Albert Trust has earned \$9,909.43 for the Foundation from 4/1/76 to 4/1/77.

2. The Wapello County Medical Society has contributed \$1,654.11 in interest on loans residing with the Foundation which total \$15,000. The county has instructed no further interest needs to be paid until so advised.

3. Two physicians (R. N. Larimer, M.D., and F. C. Coleman, M.D.) have donated sums of money previously on loan to the Foundation totalling \$600.

4. As reported last year, the Iowa Medical Society Auxiliary has acted to transfer its loan funds to the Foundation. Totally, as of 12/31/76, this fund amounted to \$27,978.92, a portion of which is in outstanding loans and which hopefully will be repaid. A portion of this loan fund available in cash was provided to the Foundation in July of 1976 in the amount of \$11,489.95.

5. As authorized by the 1973 House of Delegates, the

\$35 voluntary entry on the IMS dues statement for the Scanlon Foundation continues to produce good support. As of 4/1/77, responses had been received from 522 members totalling \$18,255; this compares favorably with \$17,340 from 495 contributors on the same date the preceding year.

In addition to the loan program, support of several projects has been continued by the Foundation. Included here are the Hawkeye Science Fair, the monthly Henry Albert Scientific Presentation in the JOURNAL, the Baldridge-Beye Lecture at the IMS Scientific Session, and a grant to the Iowa Chapter of the American Medical Student Association.

The Board of Directors of the Foundation met February 23, 1977, in Iowa City with a representative group of the student loan recipients. On this occasion special recognition was given to L. H. Jacques, M.D., Iowa City, for his valuable service as Foundation loan officer. The Board will meet also during this session of the House to review the program.

The current members of the Scanlon Board are: A. J. Havlik, M.D., John H. Kelley, M.D., Hormoz Rassekh, M.D., R. L. Wicks, M.D., V. L. Schlaser, M.D., Richard E. Hockmuth, M.D., George L. Baker, M.D., Mr. Ron Saf, Mr. Ivan Johnson, Mr. Donald L. Taylor and Mrs. W. R. Bliss.

Supplemental Reports of Standing Committees

(The Speaker asked the members of the House of Delegates to stand while J. E. Tyrrell, M.D., Chairman of the Judicial Council, read the names of the IMS members who died in 1976. The list appears on page 247 of this issue of the JOURNAL.)

NOMINATING COMMITTEE

The Nominating Committee of the Iowa Medical Society met on Sunday, March 27, 1977, and agreed upon the following slate to be presented to the House of Delegates today:

President-Elect

A. W. Boone, M.D., Davenport
R. S. Gerard, M.D., Waterloo

Vice President

M. E. Kraushaar, M.D., Fort Dodge
R. T. Melgaard, M.D., Dubuque

Speaker of the House of Delegates

L. D. Caraway, M.D., Amana

Vice Speaker of the House of Delegates

J. H. Lohnes, M.D., Cedar Rapids

Trustee (Three-year Term)

J. H. Kelley, M.D., Des Moines

Delegate to AMA (Two-year Term)

J. R. Anderson, M.D., Boone

Alternate Delegate to the AMA (Two-year Term)

E. B. Mathiasen, M.D., Council Bluffs
J. R. Scheibe, M.D., Bloomfield

Councilor, Second District (Three-year Term)

W. V. Wulfekuhler, M.D., Mason City

Councilor, Fifth District (One-year Term)

D. J. Walter, M.D., Des Moines

Councilor, Seventh District (Three-year Term)

J. E. Tyrrell, M.D., Manchester

Councilor, Eighth District (Three-year Term)

R. L. Kent, M.D., Burlington

Councilor, Ninth District (Three-year Term)

S. A. Smith, M.D., Oskaloosa

Councilor, Twelfth District (Three-year Term)

E. E. Linder, M.D., Ogden

Blue Shield Liaison Delegates to IMS

(Two to be Elected)

L. W. Goetz, M.D., Creston
C. W. Seibert, M.D., Waterloo
E. O. Theilen, M.D., Iowa City
J. D. Ver Steeg, M.D., Des Moines

Additional nominations may be accepted from the floor after which the Speaker of the House of Delegates will declare nominations closed.

The Articles of Incorporation and By-Laws require that for candidates to be unopposed for nomination, they must be unanimously approved by the Nominating Committee. Although it is recognized that it is desirable to have two candidates as a minimum for each of the proposed offices, the Nominating Committee is submitting but one candidate for some offices since these were the only names formally proposed to the Nominating Committee and were unanimously approved by the Nominating Committee. It will be noted there are four candidates for the two offices of Blue Shield Liaison Delegate to the Iowa Medical Society. Under the Articles of Incorporation and By-Laws of the Iowa Medical Society, the Liaison Committee shall submit to the Nominating Committee the names of four or more candidates for the two positions of Liaison Delegate. Therefore, under the IMS By-Laws, it is mandatory that four or more names be submitted to the Nominating Committee for these offices. These names are merely received by the Nominating Committee and submitted as a part of its report to the House of Delegates.

L. O. GOODMAN, M.D., *Chairman*
J. W. BARNES, M.D.
LESTER BEACHY, M.D.
A. F. BENETTI, M.D.
C. L. DAGLE, M.D.
R. K. FRYZEK, M.D.
J. L. GARRED, M.D.
D. C. GREEN, M.D.
K. K. HAZLET, M.D.
W. B. HOFMANN, M.D.
P. M. KAIN, M.D.
J. X. TAMISIEA, M.D.
JANET WILCOX, M.D.
P. W. WOLPERT, M.D.

Nominations from the floor were requested, but none were presented. The report of the Nominating Committee was adopted as presented.

COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

(Referred to the Reference Committee on Articles of Incorporation and By-Laws and Miscellaneous Business.)

The 1976 IMS House of Delegates adopted the following resolution:

"Resolved, That the concept of unified membership in all components of organized membership (county, state, national) be considered for establishment in the State of Iowa; that the IMS Committee on Articles of Incorporation and By-Laws draft appropriate language to implement the unified membership requirement, and that such language be submitted to the House of Delegates for consideration and action in 1977."

The standing Committee on Articles of Incorporation and By-Laws, in consultation with IMS legal counsel, has drafted appropriate language which, if adopted by the House of Delegates, would implement "unified membership."

"Resolved, That the Articles of Reincorporation of the Iowa Medical Society be and they hereby are amended by adding to Article III the following new section:

Section 7. Unified Membership. Notwithstanding any other provision of the Articles of Incorporation or By-

Laws of this Society, no physician who is eligible for active membership in this Society shall be a member of a component Society unless he or she is also an active member of this Society. Moreover, no such physician who is also eligible for active membership in the American Medical Association shall be a member of a component Society unless he or she is also an active member of the American Medical Association. This section shall become effective on January 1, 1978 and it is inapplicable to a component Society composed of student members."

The Committee does not take a position either for or against the above proposed amendment, but merely submits this language for consideration by the House of Delegates. The Committee understands that the IMS Board of Trustees and Judicial Council have had this matter under consideration and a specific recommendation will be submitted to the House of Delegates.

K. J. JUDIESCH, M.D., *Chairman*
T. M. GARY, M.D.
P. J. LEEHEY, M.D.
H. L. SKINNER, M.D.
L. W. SWANSON, M.D.

COMMITTEE ON LEGISLATION

Dr. Donald C. Young, Chairman of the IMS Committee on Legislation, presented a summary of the current status of health-related proposals before the 1977 Iowa General Assembly, and in doing so requested House consideration of legislation to authorize physician's assistants to write prescriptions. This request was referred by the Speaker to the Reference Committee on Articles of Incorporation and By-Laws and Miscellaneous Business. Following Dr. Young's remarks, Dr. Thomas E. Kiernan, Chairman of the Iowa Medical Political Action Committee, discussed the need for physician support of IMPAC.

Thomas E. Kiernan, M.D.
Chairman, Iowa Medical Political Action Committee

Dr. Kiernan told the delegates that the Iowa Medical Political Action Committee is a voluntary, non-profit, unincorporated committee of physicians and others not affiliated with any political parties. IMPAC is an independent, autonomous organization, and is not a branch subsidiary or affiliate of any national or other political action committee. The Board of Directors is appointed by the IMS Board of Trustees.

Dr. Kiernan described IMPAC's activities in the 1976 election saying that IMPAC was active in both the primary and general elections, supporting candidates for U. S. Congress and the Iowa Legislature. In four primary contests, IMPAC successfully backed the winning candidates; was active in 22 of the 26 Senate contests where 14 IMPAC-backed candidates were elected for a success ratio of 63 per cent.

In 80 House contests IMPAC backed winning candidates in 61 and supported 2 successful candidates in the U. S. Congress. IMPAC's overall success ratio was 71 per cent.

Dr. Kiernan said that 1976 was a good year for IMPAC with membership up 140 per cent over the previous year. Campaign activity increased 260 per cent over 1974 and IMPAC's success ratio increased 15 per cent over the 1974 election.

He also quoted an article from the WALL STREET JOURNAL dated April 15, 1977. The article cited an increase in business and professional PACs during 1976 from 99 to 412, with other PACs increased from 198 to 332. Dr. Kiernan said that the "PAC is where the action is," emphasizing

the importance of the concerted political efforts of medicine through PAC support of candidates.

IMPAC activities and legislative efforts are separate and distinct functions but the chairman encouraged the delegates and all physicians to belong to IMPAC and at the same time to offer personal financial support to candidates. He also encouraged personal contacts with state legislators, congressmen, and U. S. senators.

The House was told that IMPAC and AMPAC cooperate in a joint membership effort. In 1975-76 the "second effort" of physicians who contributed \$100 to the Victory '76 campaign was important to the total IMPAC effort, furnishing the committee with most of its funding for the '76 election. Dr. Kiernan told the delegates that sustaining membership in IMPAC/AMPAC is now \$100.

In final remarks the IMPAC chairman emphasized again the vital importance of the Iowa Medical Political Action Committee and called for participation by all physicians in Iowa through \$100 IMPAC/AMPAC sustaining membership and personal involvement in individual campaigns.

MEDICO-LEGAL COMMITTEE

(Referred to the Reference Committee on Legislation and Medical Service.)

The report of the Medico-Legal Committee in the 1977 HANDBOOK for the House of Delegates cites those important developments which have occurred in the professional liability area up to mid-March. This supplemental report will review these developments briefly and present additional information considered by the Medico-Legal Committee at its recent meeting on April 21, 1977.

The most noteworthy development on the 1976-77 Iowa professional liability scene has been the implementation of the Iowa Medical Society/Aetna Professional Liability Insurance Program. This program was approved by the IMS Executive Council on January 27, 1977, when it endorsed the following recommendation submitted by the Medico-Legal Committee:

"That the Iowa Medical Society enter into an agreement with the Aetna Life and Casualty to offer to member physicians the opportunity to obtain their liability insurance coverage through a program sponsored by the Society and offered by Aetna, with the authorization given to the Medico-Legal Committee, acting with endorsement from the Board of Trustees, to finalize the details of the program and proceed toward its full implementation."

The recommendation of the Committee that a sponsored program be instigated, and the subsequent approval by the Executive Council, came after extensive investigative activity. It should be recalled that consideration of such a program was urged by the 1976 House of Delegates when it approved the following resolution:

"Resolved, That the Society maintain its active liaison with the insurance industry and pursue with any reputable company the possibility of a Society-sponsored group type coverage, with any such program to be presented for approval either to the Executive Council or the House of Delegates."

As a consequence of the preceding, the IMS/Aetna Professional Liability Insurance Program had its official activation on March 15, 1977. Hereafter the program will have February 1 as its anniversary date. This common date for all policies has been established for purposes of computing potential dividends.

In the time since the program was approved, broad effort has been made to inform IMS members about its features, benefits and costs. An informational booklet was sent to all members in March with a covering letter from Society President J. F. Bishop, M.D. Further references have been carried in the IMS JOURNAL and the IMS UPDATE. Additionally, in March and April, presentations have been made at 12 county medical society meetings which were attended by more than 500 physicians. These county meetings have involved representatives of the Society and Aetna.

The informational program will be continued on an accelerated basis through 1977. The goal is to provide every IMS member with several opportunities to understand what is contained in this sponsored liability coverage and to help the member physician see how this program compares with the coverage he now has. Emphasis to date has been placed on the following main features of the program: (1) occurrence form of coverage (in contrast to claims-made); (2) guaranteed coverage (initially for three years); (3) competitive premiums; (4) comprehensive in nature with (a) professional primary liability, (b) premises liability, and (c) professional and personal catastrophe coverage; (5) direct and extensive involvement by the Society in claims review, underwriting appeals, rate determination, loss control and education, etc.; and (6) marketing through local Aetna agents.

The implementation of the IMS/Aetna program has come soon after introduction of a new Insurance Services Organization (ISO) five-digit classification system. This system for categorizing physicians according to their work has created some questions and concerns. We have been pleased at the willingness of the Aetna to address these questions. In several instances modifications have been made in accordance with Society recommendations.

Early interest and participation in the IMS/Aetna program have been gratifying. Applications are reportedly being received in the range of 8 to 10 a day. As of April 15, 1977, the number of approved applications had reached 97, with 40 of these applicants having been issued policies. With the anticipated transfer into the sponsored program of 290 physicians now individually insured by Aetna, a participation level of 400 is reasonably assured. A goal of 700/800 has been mentioned for 1977.

It should be clearly understood this is a voluntary program for interested members of the Iowa Medical Society. There are those for whom it will hold little appeal. However, its ultimate success will depend on adequate numerical participation. Consequently, the Medico-Legal Committee encourages all members to examine the program carefully and to weigh the merits of enrolling. It has both economic and non-economic benefits of substantial importance.

In concluding this section of the Medico-Legal supplemental report dealing with the IMS/Aetna Professional Liability Insurance Program, I would make two requests:

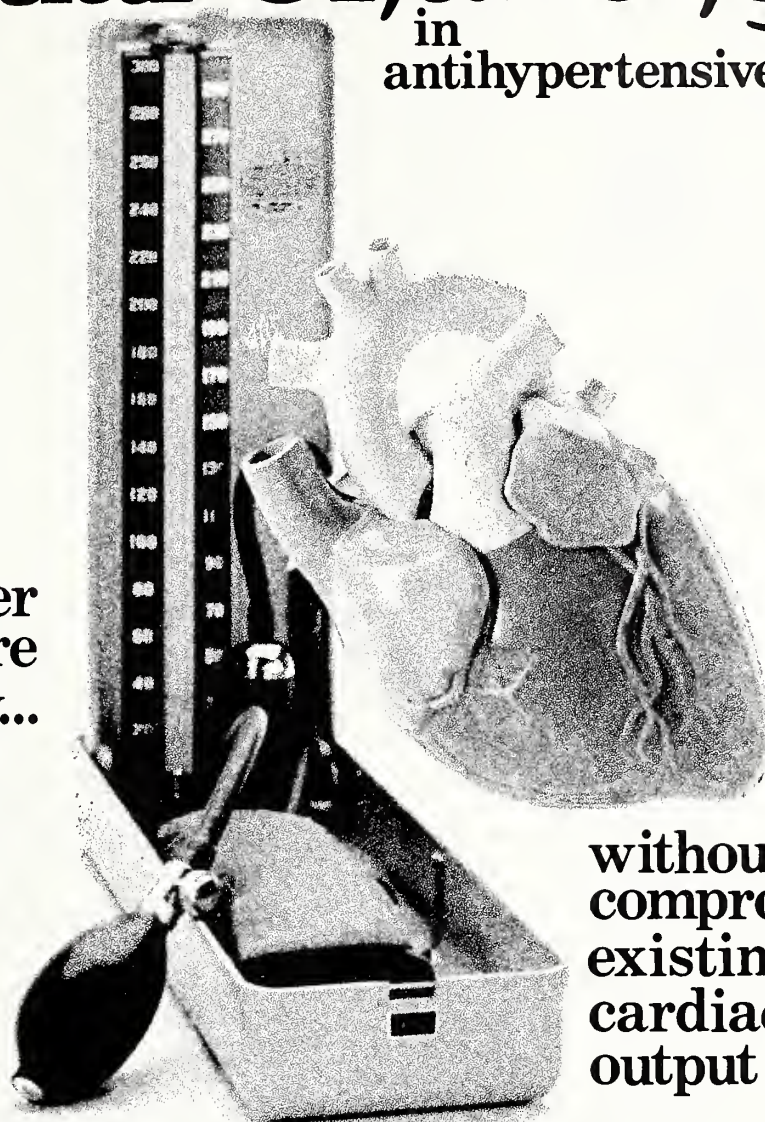
1) That the 1977 House of Delegates affirm the action of the Executive Council (taken January 27, 1977) in approving the IMS/Aetna Professional Liability Insurance Program, and

2) That the Speaker request permission from the House of Delegates to allow Mr. Roger Detrich to speak briefly about the IMS/Aetna program and to note the availability of Aetna representatives to answer questions during this meeting. Mr. Detrich has been assigned by the Aetna to serve as the program's full-time supervisor. In this capacity, Mr. Detrich is responsible for total liaison with the Society and its members.

A Dual Challenge

in
antihypertensive therapy

to lower
blood pressure
effectively...



without
compromising
existing
cardiac
output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

ALDOMET[®] (METHYLDOPA | MSD)

helps lower blood pressure effectively...
usually with no direct effect on
cardiac function—cardiac output
is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders. It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
MERCK
SHARP
DOHME

in hypertension

ALDOMET[®]

(METHYLDOPA|MSD)

helps lower
blood pressure
effectively...
usually with no
direct effect on
cardiac function—
cardiac output is
usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (707)

MSD MERCK SHARP & DOHME

Mr. Detrich reported physician participation in IMS/Aetna program is growing and every effort is being made to solve classification problems of individual physicians. He welcomed those in attendance to visit with Aetna personnel regarding their specific situations.

STATE LEGISLATION

As noted in the HANDBOOK report, effort is being made to pass additional tort reform legislation to supplement House File 803, which was enacted in 1975. House File 179 is the measure under current consideration. We are pleased to advise that H.F. 179 has passed the Iowa House of Representatives since the HANDBOOK report was prepared. With the General Assembly nearing adjournment of this session, prospects for consideration by the Senate are uncertain. However, all legislation passed by one chamber holds over for potential action during the next (1978) session. House File 179 provides for experimentation with voluntary binding arbitration; for periodic or structured payments of awards over \$50,000; a required breakdown of verdicts, and the strengthening of the Board of Medical Examiners. If not altered by amendment, the bill is regarded as worthy of enactment by the Iowa Medical Society.

OTHER ITEMS

Various matters were referred to the Medico-Legal Committee as a consequence of actions of the 1976 House of Delegates. Several of these have been responded to affirmatively through implementation of the IMS/Aetna program. Noted here are the items which have been referred:

- 1) To build on H.F. 803 with effective additional legislation. We have sought to do this with H.F. 179.
- 2) To explore creation of a state excess fund. The need here has been satisfied with implementation of the IMS/Aetna program.

- 3) To assist hardest-hit specialty groups with their liability problems. This has been accomplished with the IMS/Aetna program.

- 4) To gather statistical data for use in supporting further remedial activity. This has been pursued through the acquisition of data from the National Association of Insurance Commissioners and the American Insurance Association. The IMS/Aetna program holds considerable potential for Iowa data development as it begins to accumulate experience.

- 5) To implement a public information program. This has been done on an informal basis. Positive press coverage was obtained from the announcement of the IMS/Aetna program.

- 6) To pursue counter litigation activity. Reference material has been gathered in this area for distribution as necessary. Contact has been established with two Iowa physicians who are involved in counter litigation and with their counsel.

In closing this supplemental report, the Medico-Legal Committee again urges all Iowa physicians to become acquainted with the provisions of the IMS/Aetna Professional Liability Insurance Program and determine if it will serve their individual needs. We ask those physicians serving in the 1977 House of Delegates to take this request back to their constituents.

C. H. DENSER, JR., M.D., *Chairman*
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Supplemental Reports of Special Committees

COMMITTEE ON DELIVERY OF HEALTH SERVICES

(Referred to the Reference Committee on Articles of Incorporation and By-Laws and Miscellaneous Business.)

In response to an action of the 1976 House of Delegates, the Committee on Delivery of Health Services has expended a considerable amount of time and effort during the past year in collecting and evaluating information regarding the utilization and role of physician extenders in Iowa—i.e., physician's assistants and family nurse practitioners.

The committee has conferred with the State Board of Medical Examiners, which is responsible for the supervision and administration of the physician's assistant program in Iowa, as provided for under state legislation; Blue Cross/Blue Shield, which is involved in reimbursing physicians for services they (or their assistants) provide to Medicare and Medicaid recipients, as well as private patients; and representatives of the University of Iowa College of Medicine, which has established a Primary Care Physician's Assistants Training Program. The committee reviewed various resource materials on the subject of physician extenders—e.g., AMA reports, correspon-

dence with Iowa Senator Dick Clark re proposed legislation which would "allow Medicare/Medicaid reimbursement to health clinics where physician extenders provide primary health services"; a "Study of Attitudes Toward Physician's Assistants in Iowa" conducted by a hospital administrator in Chariton, Iowa; a status report concerning the Physician's Assistant's program in operation at the Muscatine Community Health Center; a progress and evaluation report concerning the Family Nurse Practitioner Pilot Program implemented in Iowa; and an interim report developed by the University of Iowa College of Medicine regarding the training and utilization of physician extenders in Iowa.

ENACTMENT OF THE PHYSICIAN'S ASSISTANT LAW IN IOWA

A special IMS Committee on Physician's Assistants was appointed early in January, 1971 to give careful study to the various problems and questions associated with the delegation of selected duties and functions traditionally performed by physicians, and the education and training of non-physicians (physician's assistants) to perform these duties and functions.

Soon after the committee was created, a bill "to permit doctor's assistants to work under a doctor's supervision" was introduced to the 64th Iowa General Assembly. The IMS committee held two meetings with the sponsors of the bill and, with advice and counsel from the Society's legal counsel, it was successful in amending certain sections of the proposed legislation that were not deemed appropriate.

Upon recommendation of the committee, in February, 1971, the IMS Executive Council endorsed the development of a physician's assistant program in Iowa. It expressed support for enabling legislation which would include provisions drafted by IMS legal counsel, and would give the State Board of Medical Examiners responsibility for and control of the PA program in Iowa. Such a bill was enacted into law in 1971.

FAMILY NURSE PRACTITIONER PROGRAM

In 1974, the Iowa Hospital Association requested and received funds from the Iowa Regional Medical Program for a pilot program to train six family nurse practitioners (FNPs) to render health care in Iowa. The Iowa Medical Society joined the IHA as a co-sponsor of this project, and several representatives of the Society served on an advisory committee to the project director, Sister Mary Brigid of the Iowa Hospital Association.

The basic objective of the project was to ascertain through evaluation the ability of the family nurse practitioner to deliver health care in rural areas under a physician's supervision. Six nurses and six physician preceptors participated in the project, with the nurses taking formal training courses at the University of North Dakota, and working directly with their physician preceptors. All six nurses graduated from the training program on September 25, 1975, and subsequently passed the National Certification Examination for Primary Care Physician's Assistants. Four of the six FNP's are currently employed on a full-time or part-time basis in the office of their preceptors; a fifth FNP is working in the outpatient clinics of a Des Moines hospital; the sixth FNP is employed as a public health nurse.

Last May, seven additional Iowa nurses enrolled in the FNP Program at the University of North Dakota on a private basis, with some assistance from physicians who will serve as their preceptors.

PHYSICIAN'S ASSISTANTS IN IOWA

The state's only PA training program was initiated at the University of Iowa College of Medicine in 1972 and was fully accredited by the AMA in 1975. A total of 45 persons have graduated from the 2-year program. Currently, 22 students are being accepted each year.

There are now 44 PAs employed by Iowa physicians, and approved by the Board of Medical Examiners. Thirty-two of the 44 are graduates of the University of Iowa PA Program. A majority of Iowa PAs are working in a family practice setting, although a significant percentage (34%) work in secondary or tertiary medical centers.

BOARD OF MEDICAL EXAMINERS—RULES AND REGULATIONS GOVERNING PHYSICIAN'S ASSISTANTS

Under provisions of Iowa's Physician's Assistant law, the Board of Medical Examiners has established rules and regulations governing the use of PAs in a primary care setting. Key points of these rules and regulations are summarized as follows:

* A physician's assistant is to be qualified by general education, training experience and personal character to provide patient services under the direction and supervision of an actively licensed physician in good standing. The PA shall have successfully completed a formal training program approved by the Board of Medical Examiners, or shall be otherwise qualified.

* The licensed physician shall be regarded as the employer of the PA, and shall be responsible for establishing whatever supervision is necessary. The physician's existing right to delegate various medical tasks to aides, assistants, or others acting under his supervision or direction shall not be limited.

* The supervising physician may designate another physician to direct and supervise the PA when such other physician is a member of the supervising physician's partnership, corporation, clinic or other legal entity, and when such authority to supervise a PA has been approved by the Board of Medical Examiners.

* The PA may be utilized in all medical settings, including the office, ambulatory clinic, hospital, patient's home, extended care facility, and nursing home.

* The supervising physician retains authority for patient care, although he need not be physically present at each activity of the PA, nor be specifically consulted before each delegated task is performed.

* Applications for approval of a PA must be made upon forms supplied by the Board of Medical Examiners, and submitted by the supervising physician who will assume responsibility for the assistant's performance. No physician will supervise more than two PAs at any one time.

* The PA must clearly identify himself as such when performing his duties, and shall at all times while on duty wear a name and PA identification tag.

* The assistant must generally function in reasonable proximity to the physician. If he is to perform duties away from the supervising physician, the physician must clearly specify to the Board of Medical Examiners the circumstances which justify such an action, and the written policies established to protect the patient.

* Special permission may be granted by the Board to utilize a PA in a place remote from the physician's primary treatment facility if:

—there is a demonstrated need for such utilization.

—adequate provision for immediate communication between the physician and the PA exists.

—a mechanism has been developed to provide for the establishment of a direct patient-physician relationship between the supervising physician and patients who may be seen initially by the PA.

—the responsible physician spends at least two one-half days per week in the remote office.

—adequate supervision and review of the work of the PA is provided—e.g., the supervising physician shall review at least weekly all patient care provided by the PA if it is rendered without direct consultation with the physician; the physician shall countersign all notes made by the PA.

COMMITTEE ON DELIVERY OF HEALTH SERVICES —REVIEW OF PAST YEAR'S STUDY OF PHYSICIAN EXTENDERS

As mentioned earlier in this report, the Committee on Delivery of Health Services has had opportunity to meet with various individuals who have an interest in and concerns about the role and utilization of physician extenders in Iowa. The committee has also had access to a great amount of resource and informational material. Following

is a summary of important information gleaned from these personal contacts and written materials:

Physician Extender Reimbursement Study: Mr. David Neugent, President of Blue Cross, and Mr. Robert Simmons, Vice President, Provider Relations, met with the committee on two occasions to review the involvement of Blue Cross and Blue Shield in a physician extender reimbursement study that is being conducted by the University of Southern California under a contract with the Social Security Administration.

Under the present ruling of SSA, services provided by a physician extender must be furnished under the direct personal supervision of a physician in order to be considered covered under the Medicare B and Title XIX programs. Direct personal supervision is so defined that the supervising physicians must be physically located on the premises where the services are being provided. Any services such as nursing home visits, home visits, or emergency room services that are furnished under the direct personal supervision of a physician will be considered non-covered. The experimental study is being undertaken to "determine the circumstances under which reimbursement for physician extender services should be made, and the most appropriate, equitable and non-inflationary methods and amounts of such reimbursement."

Under the study: (1) physician extenders may provide their services without the actual physical presence of the physician; (2) physician extender services will be reimbursed at 100%; (3) the physician will still be the overseer, and will still employ and bill for the PEs services; (4) claims must be assigned claims under Medicare; (5) certification and recertification of the patient in the hospital must be signed by the physician. Several Iowa physicians and their physician extenders have been designated to take part in this national study.

The committee has been informed that it is conceivable and probable that, as a result of the SSA study, there will be great pressure to drop the personal supervision requirement.

Proposed Amendments to the Social Security Act/Reimbursement for Rural Health Clinic Services:

Occurring simultaneously with the above-stated SSA Physician Extender Reimbursement Study, last fall, Iowa Senator Dick Clark conducted a series of field hearings in Iowa to discuss problems related to the financing of health services provided by physician extenders in satellite clinics. A bill is now before the Congress—H.R. 2505—which would allow Medicare reimbursement to "rural health clinics" where extenders provide primary health services. There are many inconsistencies in the proposed legislation. The AMA has expressed opposition to it as written, and has underscored the following principles which are essential in recognizing Medicare reimbursement of physician extenders: proper supervision by a physician, physician responsibility for the services as evidenced by billing in the name of the physician, and compliance with state requirements. The Iowa Medical Society has expressed similar sentiments to Senator Clark.

Study of Attitudes Toward Utilization of PAs in Iowa: This study was undertaken by George Prusynski, Administrator, Lucas County Memorial Hospital, Chariton, Iowa. Mr. Prusynski decided to study the role of the physician's assistant in Iowa after questions had been raised regarding the privileges that physician's assistants had been allowed in the Chariton hospital. His paper fulfilled requirements for a course of study at the University of Minnesota.

The author acknowledged certain limitations and fail-

ings of the study; however, he did set forth several conclusions as a result of it—e.g.,

*In general, PAs place a higher value on their services than physicians and hospital administrators place on the PAs' services.

*There is no consensus among physicians relating to the acceptance or nonacceptance of PAs. On the one hand, physicians indicated a divergence of opinion on how well other staff physicians accepted PAs. On the other hand, physicians responding to the survey strongly supported the employment of PAs in physicians' offices.

*Physicians feel a great responsibility for quality of patient care. Although they feel certain tasks should be delegated to PAs, they believe the assistant should be closely supervised.

The author recommends further study of the utilization of physician's assistants by researchers who would be able to utilize more scientific survey methods, and who would have computer assistants available to them.

Status of Primary Care Physician Training in Iowa: Paul Seeborn, M.D., Associate Executive Dean, University of Iowa College of Medicine, participated in three meetings of the Committee on Delivery of Health Services, and was most helpful and cooperative in sharing pertinent information.

One report of special interest summarized the progress that is being made toward meeting primary health care needs in Iowa. It is pointed out that Iowa currently has seven family practice residency programs in operation (Iowa City, Cedar Rapids, Davenport, Mason City, Sioux City, and two in Des Moines), and another program is scheduled to begin in Waterloo in July. The statewide network has grown from an enrollment of seven residents in 1972 to the current total of 128. When completed, the network will have a capacity for between 150-160 M.D.'s in family practice training, and will graduate 55-60 a year.

The effect of the location of residency training on the selection of final practice location is significant. Among the first sizeable class of residents to graduate from the program, 15 of 24 remained in Iowa, and 10 of these located in towns of 9,000 population or less.

It is emphasized in the report that the correction of specialty maldistribution by increasing the number of family physicians will have a self-correcting effect on geographical maldistribution down to rural towns of at least 4,000 population. For communities of lesser population, it is expected that extender service will be necessary—i.e., (1) satellite offices manned by PAs or FNP's; (2) intermittent physician visitation to a satellite; (3) improved patient transportation between a regional primary care center and the satellite, or some combination of the three.

One especially gratifying statistic contained in the report—the number of physicians practicing in Iowa communities is definitely on the upswing, with a net increase of 85 practicing physicians over five years ago.

AMA Reports

In June, 1976, a status report on physician's assistants was presented to the AMA House of Delegates, and it was referred back to the Council on Medical Service for further study and monitoring of this field. Some of the key points contained in the report are summarized as follows:

*As a general rule of law, physicians who hold unlimited licensure may delegate patient care tasks to non-licensed individuals who appear competent to perform such tasks without fear of increased exposure to legal liability. There are certain limitations, however, i.e., physicians

should delegate such tasks to individuals qualified by education, special training, or experience to perform them competently, and should be satisfied that the tasks delegated will not jeopardize the patient's safety or well-being.

*The PA always works under the general supervision of the physician, who retains overall responsibility for patient care. The AMA has recommended that the functions appropriate for delegation to the PA should best be determined by each individual physician in accordance with the above limitations, and in terms of the capabilities of a particular assistant; further, the individual utilization plans be submitted to and approved by the medical licensing authority.

*One of the important questions concerning PAs is the amount and type of supervision they should receive. There is, as yet, little consensus on this issue. Some individuals contend that the relative brief period of formal training by PAs makes it necessary for the employing physician to provide over-the-shoulder personal supervision; others believe the PA should have more responsibility and should be permitted to perform the tasks for which he is trained and qualified, away from the physical presence of his employer, so long as he is able to communicate in an acceptable manner with the physician as the need arises.

*Under all current state laws, PAs are required to function under the supervision, direction, or control of a licensed physician. However, the term "supervision" has not been defined to any significant degree. In most states, the physician is not required to be "looking over the shoulder" of his assistant, nor is he required to be in the same room. It is not anticipated the courts will define "supervision" rigidly. A too-rigid definition of supervision by the courts, legislature, or Board of Medical Examiners, would tend to dilute the effectiveness of the use of the PA in the delivery of needed services.

*In reference to PAs caring for a physician's hospitalized patients, AMA policy calls for the medical staff to recommend to the hospital governing body the extent of functions that may be delegated to the PA; and for the supervising physician to provide an appropriate medical staff committee with a description of the way he intends to use his PA, and the functions the PA will perform in the hospital.

*The AMA has recommended that reimbursement for services of a PA be made directly to the employing physician. In instances where the PA is providing services in the physician's office, the charge would appropriately be a part of the physician's own fee-for-service; in cases where the PA is physically remote from the employing physician, the AMA recommends that the physician bill for the PA's services on the basis of his usual, customary and reasonable charges, recognizing that he may, with experience, elect to reduce his charges for services provided by the PA.

At the AMA Clinical Convention in December, 1976, the House of Delegates approved the appointment of an Ad Hoc Committee on Functions and Reimbursement of New Health Practitioners, which will carry out further study and clarification requested by the House. Based on the work of this ad hoc committee, the AMA Council on Medical Service will develop guidelines for the medical profession and third party payors as to desirable supervision, methods and levels of reimbursement for physician's assistants, and other new health workers who have assumed expanded service roles. These guidelines will be submitted to the AMA House of Delegates at future meetings.

Interim Report Regarding Physician Extenders in Iowa: Attached to, and as a part of this supplemental report, is a copy of a report prepared at the University of Iowa College of Medicine at the request of Paul Seeböhm, M.D., Associate Executive Dean. It contains information regarding physician's assistants and family nurse practitioners, as well as a summary of findings from studies conducted at the Muscatine Community Health Center, which utilizes PAs. The report also includes a recommendation that on-site visits with supervising physicians and their PAs and FNP's be utilized by researchers seeking information and data regarding the utilization and effectiveness of physician extenders, and that cooperation and counsel in this regard be sought from the Iowa Medical Society and Board of Medical Examiners.

GENERAL CONCLUSION AND RECOMMENDATIONS OF COMMITTEE ON DELIVERY OF HEALTH SERVICES

It is clear to the committee that there are opposite points of view among physicians regarding the future role for physician's assistants. In the main, there is the feeling that physician extenders can provide an important service to physicians and their patients, and in extending and ensuring availability of needed services to patients. However, there is also much concern about maintaining the high quality of care, and the threat of "independent practice" by physician extenders.

As a result of its year-long review and consideration of material and information relating to the utilization and function of physician extenders in Iowa, the Committee on Delivery of Health Services submits the following recommendations to the House of Delegates:

1. **RECOMMENDATION:** That the Iowa Medical Society reaffirm and endorse legislation enacted in 1971 by the Iowa General Assembly to permit physician's assistants to function under the direction of a licensed physician, as well as the rules and regulations established by the State Board of Medical Examiners governing the use of physician's assistants in a primary care setting.

2. **RECOMMENDATION:** That reimbursement for services provided by a physician extender be made directly to the supervising physician, who may or may not have provided "direct, personal supervision" while the service was being performed.

3. **RECOMMENDATION:** That the IMS strongly oppose an "independent practice" status for physician extenders, in light of potential and serious threats to quality of health care if this should be achieved.

4. **RECOMMENDATION:** That the IMS offer its endorsement and support of appropriate evaluation studies (as determined by the Committee on Delivery of Health Services) of physician extenders that might be implemented in the future by the College of Medicine and/or Board of Medical Examiners; further, that the committee maintain close liaison and cooperation with the AMA, the Board of Medical Examiners, and the College of Medicine as new guidelines are developed and pertinent data and information become available that should come to the attention of the medical profession in Iowa.

5. **RECOMMENDATION:** That the IMS recommend to the Board of Medical Examiners that it reappoint a Physician's Assistant Advisory Committee, similar to the one that was established following enactment of Iowa's Physician Assistant statute, to review and evaluate the existing PA law, as well as rules and regulations established by the Board of Medical Examiners governing the use of PA's in the state. The new committee should in-

clude representation from medicine, osteopathy, nursing, hospitals, College of Medicine, physician's assistants, and the legislature.

6. **RECOMMENDATION:** That the IMS continue to underscore the importance of maintaining physician responsibility for the supervision and actions of the physician extender in his employ.

7. **RECOMMENDATION:** That the Committee on Delivery of Health Services continue to review pertinent data and material relating to the role and utilization of physician extenders, and to submit reports and recommendations to the IMS Executive Council and/or House of Delegates as necessary, but at least annually.

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INTERIM REPORT REGARDING PHYSICIAN EXTENDERS IN IOWA

Submitted to the Committee on Delivery of Health
Services, Iowa Medical Society—January 1977

From: Ad Hoc Committee on Evaluation of Physician
Extenders in Iowa

I. BACKGROUND

A. Introduction

In 1976 the House of Delegates of the Iowa Medical Society requested its Committee on Delivery of Health Services to continuously collect available data regarding the use of physician extenders (PEs) in Iowa. A committee report is to be presented at the annual meeting in May 1977 of the Society's House of Delegates.

In preparation for its initial report to the House of Delegates, the IMS Committee on Delivery of Health Services requested that a representative of the committee meet with Paul Seeborn, M.D., Executive Associate Dean of the University of Iowa College of Medicine, to discuss what information concerning PEs in Iowa is readily available and what studies are planned or underway in this regard.

B. Formation of the Ad Hoc Committee on Evaluation of Physician Extenders in Iowa

At the suggestion of Dr. Seeborn, several persons at the University of Iowa and elsewhere who are involved in training and/or evaluation of physician extenders, met to consider how they could aid the IMS Committee in gathering pertinent information. The group organized itself as the "Ad Hoc Committee on Evaluation of Physician Extenders in Iowa" for the immediate purpose of bringing together available information to convey to the Society. Members of the ad hoc group also agreed to make recommendations for further research. The committee agreed that its longer-run purpose would be to stimulate the development of further studies regarding PEs in Iowa. Members of the committee are:

Bruce Brenholdt, College of Medicine Administration

Toni Clow, R.N., Co-Director, Pediatric Nurse Practitioner Program

Sister Mary Brigid Condon, Project Dir., Family Nurse Practitioner Prog.

Brenda Cruikshank, M.D., Co-Director, Pediatric Nurse Practitioner Prog.

Edem Ekwo, M.D., Assoc. Director of Ambulatory and Community Pediatrics

Denis Oliver, Ph.D., Director, Physician's Assistant Program

Richard Redman, Family Practice Research Unit

Roger Tracy, College of Medicine Administration

Charles Yesalis, Ph.D., Department of Community Health

The Ad Hoc Committee adopted the following working definition of "physician extender":

a pediatric nurse practitioner (PNP), a family nurse practitioner (FNP) or a physician's assistant (PA) who works primarily in a medical setting performing medical functions delegated to them by their employer (usually a physician, but in some cases a health care organization).

The committee acknowledges that many other health providers could be regarded as physician extenders (e.g., a coronary care nurse or an emergency medical technician). This definition was selected to limit the scope of this report to the types of mid-level health practitioners thought to be of greatest interest to the IMS committee.

II. CURRENT STATUS OF PHYSICIAN EXTENDERS IN IOWA

A. Introduction

Information concerning Iowa PEs has been collected in several different ways for several different purposes in recent years. Findings from the studies that may be of possible interest to IMS are reviewed in this section of the report. The data are usually from a *sample* of Iowa PEs or employers of PEs rather than the total population of these groups. The samples are judged to be representative of their respective groups.

B. Physician's Assistants in Iowa

1. Training

The state's only PA training program is at the University of Iowa College of Medicine. The University's program is two years in length. The first class of PA students was accepted in 1972; a total of 45 persons have graduated from the program. Currently, 22 students are being accepted each year. Full accreditation of the PA program was received in 1975 from the Council on Medical Education of the AMA, following the customary provisional accreditation granted new programs.

Graduates of the University of Iowa PA Program have consistently ranked in the upper 10% on the National Certification Examination for Primary Care Physician's Assistants. The exam is conducted by the National Board of Medical Examiners under the auspices of its constituent organizations. To be eligible for recertification, a PA is required to complete 100 hours of approved continuing medical education every two years. Recertification by examination is required of PAs every six years to maintain their status as a certified physician's assistant.

2. Employment

There are currently 44 PAs employed by physicians in Iowa and approved by the Board of Medical Examiners. Thirty-two of the 44 are graduates of the University of Iowa PA Program. They represent 73% of the PAs in Iowa and 78% of the graduates of the Iowa program. PAs employed at federal health facilities in Iowa must pass the national certification exam, but they need not be approved by the Iowa Board of Medical Examiners. There are seven PAs in Iowa employed at Veterans Hospitals. It appears there are at least nine PAs working in Iowa

who are yet to be approved by the Board of Medical Examiners and who are not working at a VA hospital.

Since 1972 the Board of Medical Examiners has approved 65 applications from physicians to employ a PA. The difference between the number of applications approved and the number of PAs currently employed is explained by: PAs who have been employed by more than one Iowa physician; PAs who are now employed in other states; and PAs who are no longer employed as PAs. The communities where PAs are currently working in Iowa are shown in Attachment A.

3. Employment Characteristics

Graduates of the University of Iowa PA Program are considered representative of all PAs in the state. A majority of Iowa PAs are working in a family practice setting, although a significant percentage (34%) work in secondary or tertiary medical centers. Approximately one-third of the Iowa graduates are located in towns of less than 5,000; 44% of the graduates are in towns of less than 10,000. Data which describe several other general characteristics of PAs are summarized in Attachment B. This information was obtained at the annual Continuing Medical Education Conference for PAs held in October 1976 at the University of Iowa. The conference was sponsored jointly by the Iowa Society of Physician's Assistants and the University of Iowa PA Program. Among the re-

spondents, 80% were employed in Iowa, 82% were PAs, and 54% were graduates of the University's PA Program.

C. Family Nurse Practitioners in Iowa

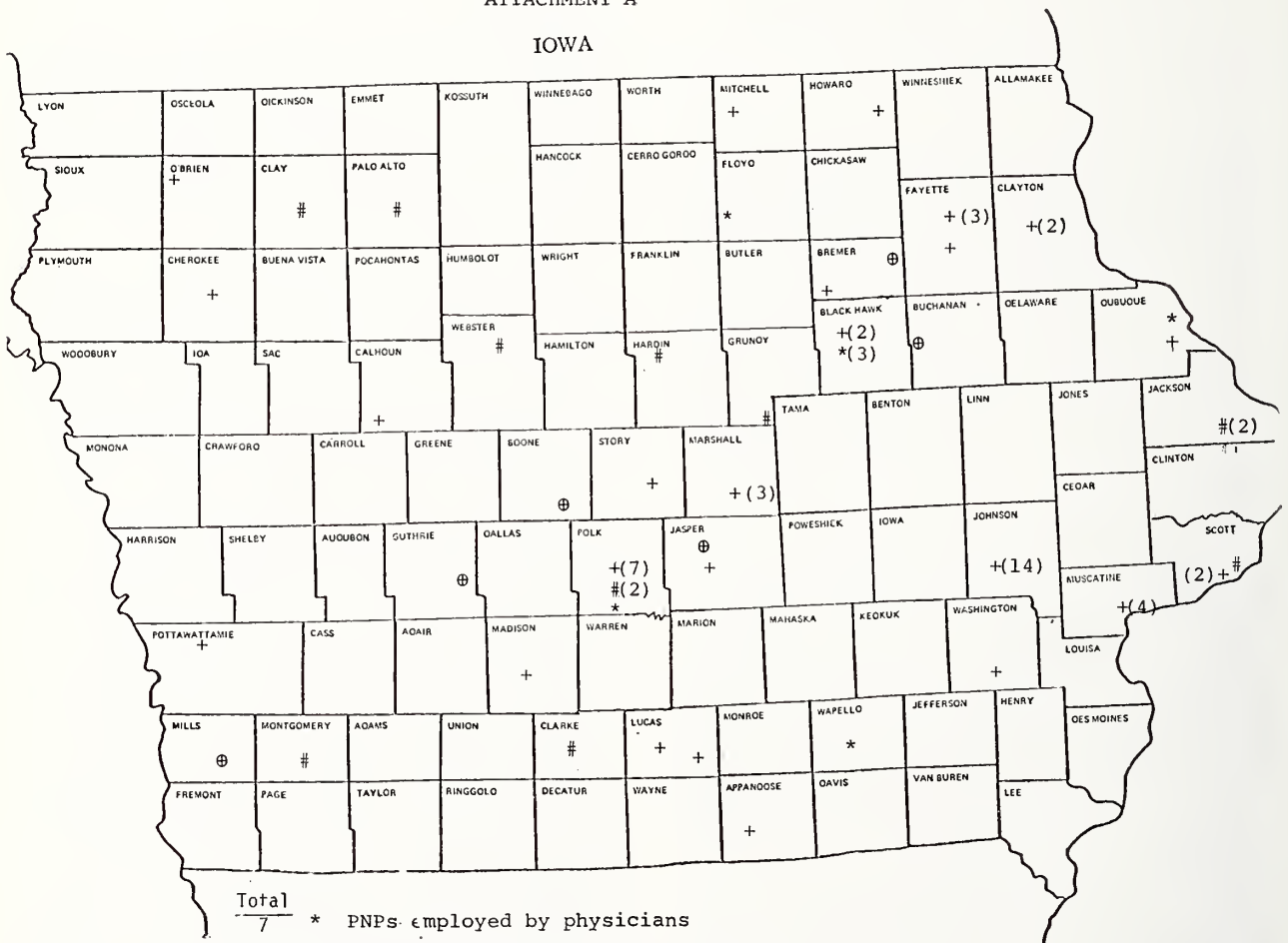
1. Training

Over 50 programs to train family nurse practitioners (FNPs) have been developed in the United States. All active FNPs in Iowa received their training at the University of North Dakota College of Medicine. FNP training, and subsequent placement in a private medical practice, was part of a pilot program involving six nurses from Iowa. The Family Nurse Practitioner Program, initiated in 1974 was co-sponsored by the Iowa Medical Society and the Iowa Hospital Association. The goal of the program was to determine if use of FNPs (under supervision of physician employers) could make primary health care more accessible in rural Iowa.

There is considerable diversity among the various FNP training programs. The University of North Dakota Program is one year in duration and divided into four didactic sessions to complement three extensive preceptorships with a primary care physician. The program's curriculum is designed to help registered nurses develop their skills, relative to patients of all ages, in history taking and giving physical exams, treating and monitoring chronic diseases and minor acute illness, and conducting and interpreting the results of routine lab tests.

ATTACHMENT A

IOWA



Total

7

* PNs employed by physicians

12 # FNPs (or FNP-trainees)

58 + PAs (⊕ indicates PA-staffed satellite clinic).

2. Employment in Iowa

All six FNP's in the pilot program completed their training and subsequently passed the National Certification Examination for Primary Care Physician's Assistants. (The FNP's took the exam voluntarily.) The employer of one FNP applied for, and received, approval from the Board of Medical Examiners customarily given PAs. The physician employers of other FNP's apparently regard the current nurse practice act in Iowa, coupled with their authority to delegate tasks to an employee, as an adequate legal basis for the employment and use of an FNP. Four of the six FNP's are still employed on a full- or part-time basis in the office of their preceptor. A fifth FNP is now working in the outpatient clinics of a Des Moines hospital. The sixth FNP is employed as a public health nurse.

Four of the FNP's originally worked in a satellite office of their supervising physician. While these satellite offices are still operational, none are staffed by an FNP. Three are staffed by one or more physicians rotating from a larger town and one is staffed full-time by a PA who is supervised by physicians in a nearby community. The experience of FNP's staffing satellite medical offices is too limited to make any assessment of the FNP's or the satellite offices.

In May 1976, seven additional Iowa nurses enrolled in the University of North Dakota FNP Program and have Iowa family physicians as preceptors. The cost of their training is being paid by the nurses, some with assistance from their individual preceptors. The communities where FNP's are currently working or taking their preceptorships are shown in Attachment A.

D. Pediatric Nurse Practitioners in Iowa

1. Training

The Pediatric Nurse Practitioner (PNP) Program at the University of Iowa is co-sponsored by the College of Nursing and the Department of Pediatrics in the College of Medicine. Since 1972 when the program began, 74 registered nurses have completed the 16 week course of study. Students are trained to function in an expanded nursing role in a variety of settings, performing numerous child health care tasks. Graduates are awarded nine semester hours of credit and a certificate of completion.

2. Employment in Iowa

A survey of PNPs from the Iowa program indicates 80% are still in the state. Almost two-thirds of the graduates are employed in some type of health care setting, while 29% hold faculty positions; 18% are employed directly by physicians. Other graduates serve in a variety of roles in hospitals and public health organizations. Consequently, only a few of the PNPs in Iowa are considered "physician extenders" according to the definition adopted by the Ad Hoc Committee. A majority are nurses functioning in an expanded role consistent with their training.

PNPs employed by Iowa physicians perform their duties under the state's nurse practice act and in conjunction with a physician's authority to delegate responsibilities to an employee. The first National Certification Examination for Pediatric Nurse Practitioners will be offered in February, 1977. The exam is being conducted under the auspices of the American Academy of Pediatrics and the National Board of Pediatric Nurse Practitioners. The sites at which PNPs are employed by Iowa physicians are shown in Attachment A.

III. FINDINGS FROM STUDIES REGARDING IOWA PHYSICIAN EXTENDERS

A. Introduction

Numerous studies have been conducted outside Iowa regarding physician extenders. "Land-mark" studies,

whose findings have been consistently replicated, indicate that:

**the care provided by properly trained and supervised physician extenders is of equivalent quality to the care given similar patients by a physician (Spitzer, et al., "The Burlington Randomized Trial of Nurse Practitioners," NEW ENGLAND JOURNAL OF MEDICINE, 290:251-256, 1974);*

**acceptance of physician extenders by patients is generally excellent (Nelson, et al., "Patients' Acceptance of Physician's Assistants," JAMA, 228:63-67, 1974);*

**physician extenders can generate sufficient revenue in a medical practice to at least equal their salary and associated overhead (Nelson, et al., "Financial Impact of Physician's Assistants on Medical Practice," NEW ENGLAND JOURNAL OF MEDICINE, 293:531-541, 1975).*

Few similar studies have been conducted at clinical settings in Iowa to verify the findings from the national studies. One reason may be that the studies cited above have come to be widely accepted among physicians and health care researchers, and there are no apparent reasons to suggest that similar studies in Iowa would yield significantly different results.

Numerous surveys conducted in Iowa have asked persons how they think a physician extender could or should be used in a clinical setting, and what benefits would be gained from use of such personnel. The first of these studies, conducted by John MacQueen, M.D., in 1971, indicated that there were a significant number of Iowa physicians who would hire a qualified PA if one were available. The University of Iowa PA training program was subsequently established.

B. Muscatine Community Health Center

A health care delivery demonstration program in Muscatine, affiliated with the University of Iowa College of Medicine, has yielded valuable information concerning the use of health care teams in a primary care group practice. Five PAs are supervised by three family physicians at the Muscatine Community Health Center. A pediatrician and an internist also practice at the Center and are available for consultation. Evaluation activities have focused on the Center's three "health care teams" (a team consists of one family physician and one or two PAs). The studies were conducted by the University of Iowa Family Practice Research Unit and by the Center's own medical staff. Findings from the studies are summarized below:

**During the initial operation of the Center, patients felt some ambiguity between the role of the physician and the role of the PA.*

**The reaction of patients who had received obstetrical services from the Center's health care teams was very satisfactory; there were no indications of dissatisfaction with the role of the PA in this regard.*

**Concerning overall patient acceptance of the health care team concept, among a sample of the Center's patients, 70% of the respondents (243) endorsed the concept; 12% indicated they did not like the concept.*

**Comparing charts of patients with selected conditions, the Center's internist found the quality of the records and care provided by the PAs is generally comparable to that of the family physicians in the Center.*

**A study compared patient revenue generated in the Center by a health care team composed of two PAs and one family physician, with a team consisting of one PA and one family physician. Under the administrative and staffing policies employed at the Center, it was found that the second PA on a team did not cover the incremental costs of employment exceeding \$12,000 per year. The limi-*

ATTACHMENT B

Note: This information is a summary of responses to a survey conducted at the 1976 Continuing Medical Education Conference for PAs at the Univ. of Iowa. The data were compiled by the University Physician's Assistant Program.

1. SEX (55) Female: 35% Male: 65% 2. AGE (56) Average Age: 30.1

3. EDUCATION (56) *Highest degree earned prior to P.A. training*

<i>High School</i> 14%	<i>Vocational</i> 4%	<i>Associate</i> 9%	<i>Undergraduate</i> 61%	<i>Registered Nurse</i> 5%	<i>Graduate</i> 7%
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4a. TYPE OF PHYSICIAN EXTENDER PROGRAM ATTENDED (55)

<i>Physician's Assistant</i> 82%	<i>MEDEX</i> 4%	<i>Nurse Practitioner</i> 7%	<i>Other</i> 7%
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4b. PHYSICIAN EXTENDER DEGREE (43)

<i>B.A./B.S.</i> 79%	<i>A.A./A.S.</i> 9%	<i>Certificate</i> 12%
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*4c. YEAR GRADUATED (52)

1967 1	1968 1	1972 4	1973 8	1974 9	1975 15	1976 14
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5. GRADUATE OF IOWA PROGRAM (56) Yes: 54% No: 46% 6. MEMBER OF AAPA (56) Yes: 75% No: 25%

7a. TYPE OF EMPLOYER (56)

<i>Private Solo</i> 16%	<i>Partnership or Group</i> 39%	<i>Clinic</i> 11%	<i>Non-profit Hospital</i> 5%	<i>Government</i> 14%	<i>University</i> 9%	<i>Other</i> 4%	<i>Unemployed</i> 2%
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7b. TYPE OF PRACTICE (55)

<i>Family Practice</i> 55%	<i>Surgery</i> 6%	<i>Internal Medicine</i> 7%	<i>Obstetrics Gynecology</i> 6%	<i>Pediatrics</i> 4%	<i>Research</i> 6%	<i>Industry</i> 2%	<i>Other</i> 14%
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8 POPULATION (55)

<i>Under 5,000</i> 29%	<i>5,000-10,000</i> 9%	<i>10,000-20,000</i> 6%	<i>20,000-50,000</i> 35%	<i>50,000-100,000</i> 4%	<i>Greater than 100,000</i> 17%
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Mean: 21,240

9. EMPLOYED IN IOWA (54) Yes: 80% No: 20%

10. HOW LONG IN PRESENT POSITION (55)

<i>Less than 6 Mo.</i> 36%	<i>6 Mo.-1 Year</i> 27%	<i>1.1-2 Years</i> 22%	<i>2.1-5 Years</i> 15%
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11. AVERAGE HOURS WORKED PER WEEK (55)

<i>Less than 40</i> 18%	<i>40-45</i> 37%	<i>45-50</i> 15%	<i>50-55</i> 20%	<i>55-60</i> 6%	<i>More than 60</i> 4%
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12a. NIGHT CALL (55) YES: 53% No: 47%

12b. HOW OFTEN (28) *Nights per month*

<i>Less than 1</i> 4%	<i>1-2.9</i> 4%	<i>3-4.9</i> 18%	<i>5-6.9</i> 18%	<i>7-9.9</i> 14%	<i>More than 15</i> 11%	<i>Every Night</i> 11%	<i>Irregular</i> 20%
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13a. INCOME (54) *Average Income per year for all respondents (Mean: \$15,000)*

<i>Less than \$10,000</i> 7%	<i>\$10,000-12,499</i> 15%	<i>\$12,500-14,999</i> 35%	<i>\$15,000-17,499</i> 17%	<i>\$17,500-20,000</i> 19%	<i>Greater than \$20,000</i> 7%
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13b. INCOME (49) *Comparison of Years of Experience/Solary*

<i>Less than One Year</i> \$13,175 (27%)	<i>One Year</i> \$14,650 (29%)	<i>Two Years</i> \$14,700 (18%)	<i>Three Years</i> \$17,200 (16%)	<i>Four Years</i> \$18,200 (8%)	<i>Eight Years</i> \$20,000 or more (2%)
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14a. FRINGE BENEFITS (56)

<i>Health Insurance</i> 59%	<i>Life Insurance</i> 46%	<i>Molproctice Insurance</i> 71%	<i>Professional Dues</i> 39%	<i>Time for Meetings</i> 88%	<i>Certification Cost</i> 43%	<i>Other</i> 30%
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14b. VACATION (44) *Days per year*

<i>10-15</i> 36%	<i>16-25</i> 41%	<i>26-30</i> 19%	<i>31-35</i> 2%	<i>36-40</i> 2%
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* Data in 4c may not be accurate because of problems in format of survey form.

tations on available facilities at the Center may also have influenced the results of the study.

*In the opinion of the Center's physicians, a significant increase in productivity was possible by using PAs without compromising the quality of care at the Center. The teams with two PAs and one family physician averaged 203 and 194 patient encounters per week compared to a national average of 132 encounters per week for a primary care physician working alone.

C. Family Nurse Practitioner Program

Evaluation of the Family Nurse Practitioner Program included interviews with the physician employers of five FNP's in Iowa. The physicians indicated:

*They have high regard for their FNP's clinical competence;

*They have a good working relationship with their FNP;

*Acceptance of the FNP has been good among their patients;

*They regard patient education and counseling as important elements of the FNP's duties.

D. Pediatric Nurse Practitioner Program

A survey of employers of PNPs showed that:

*Employment of a PNP is a satisfactory professional arrangement;

*PNPs make it possible to improve the quality of care delivered; and

*Employment of a PNP is financially feasible for the physician.

IV. EVALUATION ACTIVITIES UNDERWAY OR PLANNED

A. Physician Extender Reimbursement Study

A study involving Medicare reimbursement of physician extenders is being conducted by the University of Southern California under a contract with the Social Security Administration. The study has considerable potential for collecting relatively complete and accurate data on the range of functions and the volume of work performed by physician extenders in Iowa and the nation. To what extent this information will be made available to professional organizations and researchers in Iowa is not known at this time. Currently, ten physician extenders in Iowa (nine PAs and one FNP) are participating in the study. Several other Iowa physicians employing PEs are known to have requested to be participants in the study.

B. Muscatine Community Health Center and Red Oak Family Care Center

Two health care delivery demonstration programs, both affiliated with the College of Medicine, are expected to be the sites of further studies concerning the use and impact of PEs. Useful study comparisons are possible because of differences between the two model programs, particularly differences concerning staffing patterns and types of activities delegated to PEs. The four family physicians in the Red Oak Center employ one FNP in the central clinic and one PA to staff a satellite clinic in Malvern (population 1,158 and located 21 miles west of Red Oak).

C. Other Evaluation Activities

The Board of Medical Examiners has furnished the College of Medicine excerpts from all approved applications to the Board from Iowa physicians employing PAs. This information will enable the College to categorize the proposed activities and functions to be performed by the PA

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(as listed on the application form) and analyze the differences among the applications. At some later point, site visits to a sample of practice settings where PAs are employed would be arranged to observe the activities and functions of these PAs. Information would be collected and verified concerning task delegation, supervisory mechanisms, patient volume, malpractice coverage, arrangements for call and coverage, and, to the extent feasible, cost and revenue data.

Another study, proposed by Dr. Edem Ekwo, would examine how medical practice productivity is influenced by the sequencing of patient care-related tasks performed by members of a health care team—a physician extender, the extender's supervising physician, and other health personnel in a given medical practice. Medical practices with a physician employing a PNP and practices with a physician employing a PA would be examined. Grant support to conduct this study is being sought.

V. CONCLUSION

It is the opinion of the Ad Hoc Committee on Evaluation of Physician Extenders in Iowa that little new information of significance can be gained by further distribution of questionnaires to Iowa physicians employing physician extenders and to the extenders. The committee recommends that future research regarding extenders rely more on direct observation and use of practice-based information systems, and less on questionnaires.

A close working relationship between University-based researchers on one hand, and the Society and the Board on the other, would help:

*achieve a mutual understanding of important research questions;

*improve access by researchers to reliable information about physician extenders in Iowa;

*obtain better cooperation from physicians and physician extenders for research activities;

*keep Iowa physicians better informed concerning research activities involving PEs;

*increase the likelihood that research findings relating to PEs can be considered in the formation of public policy.

The committee recommends that persons developing research plans involving physician extenders seek the advice and cooperation of the Iowa Medical Society and the Iowa Board of Medical Examiners.

RESOLUTIONS

CERRO GORDO COUNTY MEDICAL SOCIETY NO. 1 REFORM OF OPTOMETRIC PRACTICE ACT

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, The optometrists of the State of Iowa do not possess the medical degree and qualifications necessary for the proper and judicious use of diagnostic or therapeutic drugs, and

WHEREAS, The Legislature has been asked to amend the law to permit optometrists to use these drugs, therefore be it

Resolved, That the Iowa Medical Society oppose legislation granting the use of diagnostic and/or therapeutic drugs by reform of the Optometric Act.

BLACK HAWK COUNTY MEDICAL SOCIETY NO. 2 EXECUTIVE SECRETARY SERVICES

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Miscellaneous Business.)

WHEREAS, local medical leaders are being required to become more involved in matters concerned with medicine in their communities, and

WHEREAS, the only designated representative of organized medicine in the local community is usually the county society president, and

WHEREAS, the president of such a society invariably has to maintain a full-time practice and therefore does not have time to respond to the demands of the office, and

WHEREAS, for the reasons as outlined above, it is becoming increasingly difficult to find physicians who are willing to serve in this office, and

WHEREAS, A capable and knowledgeable lay person in the role of executive secretary could assist the president of the county society and lessen the demands of the office, therefore be it

Resolved, That the Iowa Medical Society, through its Executive Council or one of its committees, study the feasibility of setting up a program to assist county medical societies in organizing in such a manner that services of an executive secretary could be shared by several such societies and in that way, ease the burden of the office of county society president.

J. X. TAMISIEA, M.D., DELEGATE CLAY COUNTY MEDICAL SOCIETY NO. 3 PATIENT'S RECORDS*

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, Legislation has been proposed in the Iowa General Assembly to make certain all patient records (charts, slides, x-rays, reports, etc.) are the property of each patient, and

WHEREAS, The surrendering of this material to the patient could be disastrous to the delivery of orderly, intelligent medical care, and

WHEREAS, If the originals must be given to each patient, the duplication of these materials, in order for each physician to maintain an orderly file as he now does, will increase the cost of medical care, and

WHEREAS, All patients now can have the records, etc., made available to a new physician, and

WHEREAS, There is no demonstrated need for such disruptive legislation, therefore be it

Resolved, That the IMS House of Delegates oppose the enactment of such legislation.

J. X. TAMISIEA, M.D., DELEGATE CLAY COUNTY MEDICAL SOCIETY NO. 4 CERTIFICATE OF NEED LEGISLATION*

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, House File 354 has been introduced in the Iowa General Assembly to require that individual physicians in private practice must obtain a "certificate of need" to purchase equipment, etc., to enhance his ability to deliver medical care, and

WHEREAS, Such legislation would infringe on each physician's ability to determine what is the best care for his patients, and

WHEREAS, The scope of such legislation is usually expanded after its initiation, therefore be it

Resolved, That the IMS House of Delegates oppose any

* Resolutions 3, 4 and 5 were supported at the caucus of Councilor District III.

and all similar attempts to interfere with the private practice of medicine.

J. X. TAMISIEA, M.D., DELEGATE

CLAY COUNTY MEDICAL SOCIETY

NO. 5 EMPLOYMENT OF RADIOLOGISTS AND PATHOLOGISTS*

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, Senate File 68 has been introduced in the Iowa General Assembly to change Chapter 135B of the Iowa Code to allow hospitals to employ radiologists and pathologists on salary, and

WHEREAS, There is no evidence this will result in better or less expensive medical care, and

WHEREAS, This may in fact alter or disrupt the delivery of medical care in Iowa, and

WHEREAS, The practice of pathology and radiology are the practice of medicine, and

WHEREAS, This change in the law would allow for the corporate practice of medicine by eleemosynary institutions, therefore be it

Resolved, That the IMS House of Delegates oppose the proposed change in Chapter 135B of the Code, and reaffirm its belief that no physician should be a salaried employee in a private eleemosynary institution.

STORY COUNTY MEDICAL SOCIETY

NO. 6 RESTRAINT ON MEDICAL FEES

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, Inflation continues as a serious threat to the general economic well-being of the United States; and

WHEREAS, The cost of health care is one of the principal contributors to this inflation spiral (8.9% of Gross National Product); and

WHEREAS, Physicians (who receive approximately 17% of the sum spent for medical care) have a duty and obligation to be mindful of and concerned about these trends; and

WHEREAS, Such a policy might constitute a focal point for the development of a blueprint to be followed by the Iowa Medical Society as a formal and conscientious response to this significant challenge; therefore be it

Resolved, That the Iowa Medical Society urge its member physicians to pursue actively and personally efforts to understand those factors which bear on the cost of health care as it is delivered locally and to restrain voluntarily any fee increase to not exceed the cost of living increase for the previous year where this is practical and is not likely to jeopardize the quality of medical care available.

POLK COUNTY MEDICAL SOCIETY

NO. 7 TEENAGE PREGNANCY

(Referred to Reference Committee on Articles of Incorporation and By-Laws and Miscellaneous Business.)

WHEREAS, Teenage or adolescent pregnancies have reached an alarming level in the State of Iowa, and

WHEREAS, This situation constitutes a growing public health problem in terms of risk to both mother and baby; therefore be it

Resolved, That the Iowa Medical Society House of Delegates request the Committee on Maternal and Child Health to (a) study the magnitude of the adolescent pregnancy problem in Iowa, (b) prepare a report setting forth causes, risks, etc., associated with the problem, and

(c) develop recommendations for use by the medical profession, parents, school boards, other educational facilities, and the general public, in dealing with the matter, and be it further

Resolved, That the report of the Committee on Maternal and Child Health be submitted either to the Executive Council or House of Delegates for approval prior to any distribution.

LIFE AND ASSOCIATE MEMBERSHIPS

LIFE MEMBERSHIPS RECOMMENDED ON THE BASIS OF 50 YEARS' PRACTICE AND THE LAST 15 CONSECUTIVE YEARS' MEMBERSHIP

County	Name
Dallas-Guthrie	Charles A. Nicoll, M.D., Panora
Fremont	A. Roy Wanamaker, M.D., Hamburg
Polk	Julian M. Bruner, M.D., Des Moines
	David W. James, M.D., Des Moines
Woodbury	Peirce D. Knott, M.D., Sioux City

ASSOCIATE MEMBERSHIPS RECOMMENDED ON THE BASIS OF RETIREMENT OR INCAPACITATION

County	Name
Black Hawk	Herbert Shulman, M.D., Waterloo
Boone	Ralph L. Wicks, M.D., Boone
Butler	Fred A. Rolfs, M.D., Aplington
Cerro Gordo	Dean W. Clapsaddle, M.D., Clear Lake
	Franklin W. Kapke, M.D., Mason City
	Draper L. Long, M.D., Mason City
	Guido J. Sartor, M.D., Mason City
	Rodger B. Smith, M.D., Mason City
Crawford	Charles H. Fee, M.D., Salem, Oregon
Dubuque	Luke A. Faber, M.D., Dubuque
Johnson	Janis Straumanis, M.D., Solon
Keokuk	Franklyn C. Perkins, M.D., Hedrick
Polk	Jerome G. Bashara, M.D., Des Moines
	Addison W. Brown, Sr., M.D., West Des Moines
	Fred Dinkler, M.D., Des Moines
	Alonzo L. Jenks, Jr., M.D., Des Moines
	Harold L. Klocksien, M.D., Des Moines
	Charles A. Nordin, M.D., Des Moines
	Thomas M. Schwink, M.D., Des Moines
	F. Eberle Thornton, M.D., Des Moines
	Dwight C. Wirtz, M.D., Des Moines
Pottawattamie-Mills	W. Clark Giles, M.D., Council Bluffs
	William O. Griffith, M.D., Council Bluffs
Scott	Aileen Mathiasen Sciortino, M.D., Council Bluffs
	Hymen M. Hurevitz, M.D., Davenport
	Lester W. Kimberly, M.D., Bettendorf
	Augustus B. Kuhl, M.D., Davenport
	David F. Weaver, M.D., Davenport
Shelby	Carl V. Bisgard, M.D., Harlan
Story	David C. Alftine, M.D., Ames
Wapello	John A. Dotterer, M.D., Ottumwa
Woodbury	Carroll A. Brown, M.D., Sioux City

As the Iowa Medical Society representative to the Iowa Medical Assistance Advisory Council, Dr. Havlik requested permission to distribute a questionnaire to determine the level of physician participation in the Iowa Medicaid program. The request was granted and the survey form, provided by the Department of Social Services, was distributed.

Dr. Bliss nominated IMS members for life and associate memberships. The physicians nominated for each of these membership categories were approved unanimously.

The Speaker advised the delegates of the time and locations of the several reference committee hearings. It was explained the House would reconvene at 8:30 a.m. on Saturday, May 7, 1977, and voting would be the first order of business. The opening session was adjourned at 12:50 p.m.

In the course of the morning proceedings, the Speaker acknowledged the presence of several distinguished guests—Mrs. Jeanne Green, president-elect of the American Association of Medical Assistants; Dr. Eli Goodman, president-elect of the Indiana Medical Society, and Dr. George T. Wilkins, president of the Illinois Medical Society.

SATURDAY SESSION, MAY 7, 1977

The Saturday session of the House of Delegates was called to order at 8:30 a.m. The House approved the taking of attendance by registration cards. There were 119

delegates, 18 voting alternates and 15 ex-officio members present. Delegates were provided reference committee reports and ballots at the time of registration.

COUNTY	DELEGATE	COUNTY	DELEGATE	COUNTY	DELEGATE
Appanoose	A. S. Owca	Johnson	K. J. Judiesch		A. B. Grundberg*
Black Hawk	C. D. Ellyson		K. D. Dolan		J. W. Olds*
	R. S. Gerard		S. W. Greenwald		D. L. Sweem*
	R. E. Hedican, Jr.		R. E. Rakel		L. F. Parker*
	J. G. Napier		D. E. Schnetzler		D. J. Walter*
	A. M. Dolan*		P. M. Seeborn		J. K. Uchiyama*
Boone	E. E. Linder		M. D. Sokoll	Pottawattamie-Mills	J. L. Knott
Bremer	G. J. Kimball		R. D. Whinery		E. B. Mathiasen
Buchanan	P. J. Leehey		J. B. Wilcox		G. L. Neligh
Buena Vista	T. E. Shea	Jones	A. P. Randolph		M. E. Olsen
Calhoun	R. P. Ferguson	Kossuth	M. D. Rooney		A. M. Romano
Cerro Gordo	A. G. Chanco	Linn	R. J. Barry	Poweshiek	R. K. Fryzek
	W. G. Garrett		R. W. Conkling	Scott	H. R. Light
	R. E. McCoy		A. C. Hass		A. W. Boone
	R. M. Powell		J. H. Lohnes		J. C. Barker
	W. C. Rosenfeld		J. W. Reinertson		W. B. Hofmann
	D. D. Van Etten		W. J. Robson		R. M. Perkins, III
Cherokee	G. E. Michel		R. A. Sautter		J. C. Donahue, Jr.*
Chickasaw	J. C. Carr		G. R. Wessel		P. L. Rohlf*
Clay	J. X. Tamisiea	Mahaska	S. A. Smith		W. F. Ramsey
Clinton	G. T. Schmunk	Marion	J. E. Griffin	Shelby	J. H. Spearing
Crawford	D. J. Soll	Marshall	L. O. Goodman	Sioux	E. B. Grossmann, Jr.
Dallas-Guthrie	N. L. Krueger		W. T. Shultz	Story	W. R. Bliss
	E. E. Lister		R. G. Boeke		G. J. Hegstrom
Davis	H. M. Perry	Mitchell	J. L. Garred		Charles Jons
Decatur-Ringgold	D. E. Mitchell	Monona	D. N. Orelup	Tama	C. J. Chapple
Delaware	J. E. Tyrrell	Monroe	K. E. Wilcox	Union-Taylor	A. J. Havlik
Des Moines-Louisa	K. A. Hahn	Muscatine	R. L. Zoutendam	Wapello	R. H. Kuhl
	R. L. Kent	O'Brien	W. E. Hicks		L. E. Coppoc
	J. P. Stoikovic	Osceola	J. P. Trotzig		K. E. Lister*
Dickinson	D. F. Rodawig, Jr.	Plymouth	J. M. Rhodes, Sr.	Washington	D. G. Sattler*
Dubuque	J. S. Chapman	Pocahontas	Lester Beachy	Wayne	K. A. Garber
	K. K. Hazlet	Polk	R. T. Brown	Webster	D. J. Lulu
	R. T. Melgaard		M. H. Dubansky		M. E. Kraushaar*
	J. W. White		J. L. Fatland	Woodbury	R. A. Boldus
Emmet	H. A. Lindholm		Marshall Flapan		G. J. McGowan
Fremont	F. M. Ashler		John Hess, Jr.		J. S. Pennepacker
Greene	E. D. Thomson*		D. O. Newland		H. V. Robison
Grundy	D. R. Kruschwitz		L. J. Plummer		R. T. Satterfield
Hamilton	G. A. Paschal		A. N. Smith		P. W. Wolbert
Hancock-Winnebag	L. R. Fuller		D. C. Young		D. M. Youngblade
Hardin	T. C. Graham		R. W. Adams*		B. H. Osten
Harrison	J. W. Barnes		R. F. Birge*	Worth	A. F. Benetti
Humboldt	J. H. Coddington		C. H. Denser, Jr.*	Wright	
Jackson	J. A. Broman		L. O. Elv*		
Jasper	T. E. Kiernan		R. D. Eckoff*		

* Alternate

LIAISON DELEGATES

C. W. Seibert J. D. Ver Steeg

EX-OFFICIO MEMBERS OF THE HOUSE

J. F. Bishop	Erling Larson, Jr.
L. W. Swanson	J. R. Anderson
T. A. Burcham	J. R. Scheibe
J. H. Kelley	V. L. Schlaser
Hormoz Rassekh	J. W. Eckstein
W. V. Wulfekuhler	R. L. Wicks
A. L. Sciortino	J. H. Sunderbruch
L. D. Caraway	

Dr. Bliss read the minutes of the May 6 meeting of the House of Delegates and the House approved them. The Speaker introduced the following guests—Dr. Robert Leitch, president, Michigan State Medical Society; Dr. Richard Anonsen, president, Minnesota State Medical Association; Dr. George Wilkins, president, Illinois Medical Society; Dr. Eli Goodman, president, Indiana State Medical Society, and Dr. Charles Picard, past president, State Medical Society of Wisconsin.

The Speaker introduced Mrs. Carroll Adams, president of the Iowa Medical Society Auxiliary, for brief comments. She noted the Auxiliary has as its main objective assisting the Society in the advancement of medicine and public health. She thanked the Society for its moral and monetary support. She outlined 1976-77 Auxiliary activity and mentioned involvement in immunization, child abuse, health education and nutrition, legislative relations, AMA-ERF, etc. She noted the Auxiliary membership is

1,230, surpassing the goal of 1,200.

The election of officers occurred and the following physicians were chosen:

President-elect	R. S. Gerard, M.D., Waterloo
Vice-President	R. T. Melgaard, M.D., Dubuque
Trustee (3 year term)	J. H. Kelley, M.D., Des Moines
Speaker of the House	L. D. Caraway, M.D., Amana
Vice Speaker of the House	J. H. Lohnes, M.D., Cedar Rapids
Delegate to AMA (2 year term)	J. R. Anderson, M.D., Boone
Alternate Delegate to AMA (2 year term)	E. B. Mathiasen, M.D., Council Bluffs
Blue Shield Liaison	C. W. Seibert, M.D., Waterloo
Delegates to IMS	J. D. Ver Steeg, M.D., Des Moines
Councilor, District 2	W. V. Wulfekuhler, M.D., Mason City
Councilor, District 5	D. J. Walter, M.D., Des Moines
Councilor, District 7	J. E. Tyrrell, M.D., Manchester
Councilor, District 9	S. A. Smith, M.D., Oskaloosa
Councilor, District 12	E. E. Linder, M.D., Ogden

Dr. Caraway thanked the members of the Reference Committees and asked delegates desiring to serve in this important capacity, to direct their inquiries to the Speaker, IMS Headquarters. He then informed the delegates of the proper procedure for debate and voting on the Reference Committee Reports.

REFERENCE COMMITTEE REPORTS

The following Reference Committee reports were acted upon by the House of Delegates.

COMMITTEE ON LEGISLATION AND MEDICAL SERVICE

The Reference Committee on Legislation and Medical Service met in open session at 2 p.m., Friday, May 6, 1977. The hearing was attended by more than 50 physicians and delegates. Comments were received on the various resolutions and one report during the two and one-half hour session.

The Reference Committee submits the following report and feels the recommendations contained herein are in the best interest of medicine and the public. The Reference Committee submits the following report for action by the House of Delegates.

RESOLUTION NO. 1—INTRODUCED BY CERRO GORDO COUNTY MEDICAL SOCIETY REFORM OF OPTOMETRIC PRACTICE ACT

Nearly half of the time spent in committee hearing was devoted to the discussion of the "Reform of Optometric Practice Act." The committee heard testimony supporting the official IMS position in opposition to the use of diagnostic and therapeutic drugs by optometrists. Those against the IMS position spoke on grounds that optometry is a profession based on scientific principles delivering eye care to a significant portion of the population and that the use of drugs would be beneficial to them for diagnosis.

The committee feels the resolution submitted by the Cerro Gordo County Medical Society is similar in nature to the resolution approved by the 1976 IMS House of Delegates.

RECOMMENDATION: The Reference Committee recommends reaffirmation of the action taken by the 1976 House of Delegates in lieu of Resolution No. 1.

Resolved, That the Iowa Medical Society oppose state legislation which permits the use of drugs by optometrists for diagnostic or therapeutic purposes, and be it further

Resolved, That the Iowa Medical Society affirm the basic belief that physicians in the practice of ophthalmology are the primary providers of eye care and that attempts to erode this concept be resisted actively.

Mr. Speaker, I move the adoption of these resolutions.

RESOLUTION NO. 3—INTRODUCED BY J. X. TAMISIEA, M.D. DELEGATE, CLAY COUNTY MEDICAL SOCIETY PATIENT'S RECORDS

The resolution objects to legislation which would make patient's records the property of the patient. The Committee agrees with the intent of the resolution and referred to the "Judicial Council Opinion and Reports" of the American Medical Association which states: "At the request of the patient, preferably in writing, reports should be immediately sent to the doctor then in charge of the patient. Whether the contents of the report are to be given to the patient rests with the decision of the doctor who knows all the circumstances involved in the situation."

RECOMMENDATION: The Reference Committee recommends the adoption of the following resolution in lieu of Resolution No. 3:

Resolved, That the IMS oppose the enactment of legislation which would make patient's records the property of the patient.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 4—INTRODUCED BY J. X. TAMISIEA, M.D., DELEGATE, CLAY COUNTY MEDICAL SOCIETY CERTIFICATE OF NEED LEGISLATION

The intent of the resolution is to object to the inclusion of individual physicians in private practice in any "certificate of need" legislation. The committee feels that the position adopted by the Executive Council on January 27, 1977 should receive formal approval of the IMS House of Delegates.

RECOMMENDATION: The Reference Committee recommends the adoption of the following resolution in lieu of Resolution No. 4:

Resolved, That the IMS oppose the inclusion of the offices and services of a private physician or clinic in any "certificate of need" legislation.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 5—INTRODUCED BY J. X. TAMISIEA, M.D., DELEGATE, CLAY COUNTY MEDICAL SOCIETY EMPLOYMENT OF RADIOLOGISTS AND PATHOLOGISTS

The resolution, as proposed by the delegate from the Clay County Medical Society, referred specifically to Senate File 68 introduced in the Iowa General Assembly proposing to amend Chapter 135B of the Iowa Code to allow hospitals to employ radiologists and pathologists on salary. Much testimony was received during the Reference Committee hearing and the subject was discussed at some length in executive session. The Committee agrees with the intent of Resolution No. 5.

RECOMMENDATION: The Reference Committee submits the following substitute resolution in lieu of Resolution No. 5.

Resolved, That the IMS oppose any change in Chapter 135B of the Iowa Code which would permit employment of salaried physicians by hospitals, which then sell their services to the public.

Mr. Speaker, I move the adoption of the foregoing resolution.

RESOLUTION NO. 6—INTRODUCED BY STORY COUNTY MEDICAL SOCIETY RESTRAINT ON MEDICAL FEES

The Story County resolution considers inflation a serious threat to the general economic well-being of the United States and recognizes published figures indicating that health care constitutes 8 to 9 per cent of the gross national product, with physicians receiving approximately 17 per cent of that amount. The Committee referred to the "Opinions and Reports of the Judicial Council" of the American Medical Association and wishes to call the following excerpt to the attention of the House: "That a physician try, in matters relating to fees, to the best of his ability to insure justice to the patient and himself and respect for his profession."

RECOMMENDATION: The Reference Committee recommends the following substitute resolution in lieu of Resolution No. 6:

Resolved, That the Iowa Medical Society urge its member physicians to continue to be aware of those factors which bear on the cost of health care.

Mr. Speaker, I move the adoption of the foregoing resolution.

The Reference Committee received and reviewed the

reports of the Iowa Foundation for Medical Care and Blue Shield of Iowa. The reports called for no action and were received for information only.

SUPPLEMENTAL REPORT OF THE MEDICO-LEGAL COMMITTEE

The Reference Committee took note of the Supplemental Report and wishes to make the following recommendations:

RECOMMENDATION:

Resolved, That members of the Medico-Legal Committee be commended by the House of Delegates for their expedient and appropriate action in investigating and implementing an alternate system of professional liability coverage for IMS members.

Mr. Speaker, I move the adoption of the foregoing resolution.

RECOMMENDATION:

Resolved, That the IMS House of Delegates affirm the January 27, 1977 action of the Executive Council in approving the IMS/Aetna Professional Liability Insurance Program.

Mr. Speaker, I move the adoption of the foregoing resolution.

This concludes the report of the Reference Committee on Legislation and Medical Service.

PAUL FERGUSON, M.D., *Chairman*
W. J. ROBSON, M.D.
JANET WILCOX, M.D.
W. C. ROSENFELD, M.D.
G. E. MICHEL, M.D.

At this point, Dr. Hazlet commented, "I think this House owes a specific and personal word of thanks to our chairman, Dr. Denser." The House responded unanimously.

ARTICLES OF INCORPORATION AND BY-LAWS AND MISCELLANEOUS BUSINESS

The Reference Committee on Articles of Incorporation and By-Laws and Miscellaneous Business met in open session at 2 p.m., Friday, May 6, 1977. Comments were received on the several reports and resolutions during the two-hour open hearing. The Committee wishes to thank the nearly 40 physicians who attended the hearing and provided useful testimony.

The following report has been prepared in an effort to reflect the sentiment of those testifying at the hearing and is submitted for consideration and action by the House of Delegates.

SUPPLEMENTAL REPORT OF THE STANDING COMMITTEE ON

ARTICLES OF INCORPORATION AND BY-LAWS

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES

(SECTION II—FINANCES) (ITEM NO. 4, LINES 29-37)

Acting in accordance with instructions from the 1976 Iowa Medical Society House of Delegates, the Standing Committee on Articles of Incorporation and By-Laws submits in its 1977 supplemental report language to allow implementation of the "unified membership" concept.

The language developed by the Committee to authorize "unified membership" reads as follows:

Resolved, That the Articles of Reincorporation of the Iowa Medical Society be and they hereby are amended by adding to Article III the following new section:

Section 7. Unified Membership. Notwithstanding any other provision of the Articles of Incorporation or By-Laws of this Society, no physician who is eligible for active membership in this Society shall be a member of a

component Society unless he or she is also an active member of this Society. Moreover, no such physician who is also eligible for active membership in the American Medical Association shall be a member of a component Society unless he or she is also an active member of the American Medical Association. This section shall become effective on January 1, 1978 and it is inapplicable to a component Society composed of student members.

In its evaluation of this proposal, as set forth in the Finance Section of its Report, the Board of Trustees has indicated its support for a retention of the voluntary membership concept. The Board has called attention to the ability of individual county medical societies to institute the "unified membership" approach (county and state) at their individual option.

Testimony presented to the Reference Committee was in near-unanimous support of the position espoused by the Board of Trustees.

RECOMMENDATION: The Reference Committee recommends adoption of the following substitute resolution in lieu of the resolution offered by the Standing Committee on Articles of Incorporation and By-Laws.

Resolved, That the Articles of Reincorporation of the Iowa Medical Society be retained as presently structured with respect to membership affiliation.

Mr. Speaker, I move the adoption of this substitute resolution.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON DELIVERY OF HEALTH SERVICES

The Reference Committee wishes to commend the Committee on Delivery of Health Services for its informative report on the physician extender in the State of Iowa, and the additional report prepared by the multidiscipline Ad Hoc Committee on Evaluation of Physician Extenders in Iowa.

The aforementioned reports, plus the worthwhile testimony presented by various interested and involved physicians, will serve a useful reference purpose for the medical profession. Support was expressed for the 1971 Iowa Physician's Assistant Law in both the report and in the oral remarks. Society members who employ physician's assistants were encouraged to be mindful of the law and its regulations, as they have been devised and implemented by the State Board of Medical Examiners.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolution:

Resolved, That the Supplemental Report of the Committee on Delivery of Health Services be received and the following recommendations be approved.

RECOMMENDATION: That the Iowa Medical Society reaffirm and endorse legislation enacted in 1971 by the Iowa General Assembly to permit physician's assistants to function under the direction of a licensed physician, as well as the rules and regulations established by the State Board of Medical Examiners governing the use of physician's assistants in a primary care setting.

RECOMMENDATION: That reimbursement for services provided by a physician extender be made directly to the supervising physician, who may or may not have provided "direct, personal supervision" while the service was being performed.

RECOMMENDATION: That the IMS strongly oppose an "independent practice" status for physician extenders, in light of potential and serious threats to quality of health care if this should be achieved.

RECOMMENDATION: That the IMS offer its endorsement and support of appropriate evaluation studies (as determined by the Committee on Delivery of Health ser-

vices) of physician extenders that might be implemented in the future by the College of Medicine and/or Board of Medical Examiners; further, that the committee maintain close liaison and cooperation with the AMA, the Board of Medical Examiners, and the College of Medicine as new guidelines are developed and pertinent data and information become available that should come to the attention of the medical profession in Iowa.

RECOMMENDATION: That the IMS recommend to the Board of Medical Examiners that it reappoint a Physician's Assistant Advisory Committee, similar to the one that was established following enactment of Iowa's Physician Assistant statute, to review and evaluate the existing PA law, as well as rules and regulations established by the Board of Medical Examiners governing the use of PA's in the state. The new committee should include representation from medicine, osteopathy, nursing, hospitals, College of Medicine, physician's assistants, and the legislature.

RECOMMENDATION: That the IMS continue to underscore the importance of maintaining physician responsibility for the supervision and actions of the physician extender in his employ.

RECOMMENDATION: That the Committee on Delivery of Health Services continue to review pertinent data and material relating to the role and utilization of physician extenders, and to submit reports and recommendations to the IMS Executive Council and/or House of Delegates as necessary, but at least annually.

Mr. Speaker, I move the adoption of this resolution.

ORAL REQUEST—CHAIRMAN, IOWA MEDICAL SOCIETY
COMMITTEE ON LEGISLATION

In his remarks to the opening session of the 1977 House of Delegates, Donald C. Young, M.D., Chairman of the Legislative Committee, requested an expression from the House with respect to proposed state legislation (S.F. 357) to authorize physician's assistants to write and sign prescriptions upon the direct order of the supervising physician.

No specific testimony was presented to the Reference Committee in favor of prescription writing by physician's assistants. There is an obvious need for the supervising physician to work closely with his PA in determining the best possible care regimen for each and every patient.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolution.

Resolved, That the Iowa Medical Society oppose legislation granting the physician's assistant statutory authority to write prescriptions.

Mr. Speaker, I move the adoption of this resolution.

RESOLUTION NO. 2—INTRODUCED BY
BLACK HAWK COUNTY MEDICAL SOCIETY
EXECUTIVE SECRETARY SERVICES

This resolution requests exploration by the Iowa Medical Society of ways in which the IMS can assist county medical societies in supporting the services of an executive secretary. Arrangements now existing in various counties for full- or part-time staff assistance were reported to the sponsor of the resolution. In addition, note was made of the several administrative services provided by the Iowa Medical Society to interested county medical societies. These comments were acknowledged with appreciation by the sponsor.

RECOMMENDATION: The Reference Committee recommends adoption of the following substitute resolution.

Resolved, That the matter of providing further adminis-

trative assistance to county medical societies (as set forth in Resolution No. 2) be referred to the Board of Trustees for study and implementation as possible.

Mr. Speaker, I move the adoption of this substitute resolution.

RESOLUTION NO. 7—INTRODUCED BY POLK COUNTY
MEDICAL SOCIETY
TEENAGE PREGNANCY

The sponsor of this resolution was supported totally in his cause by those attending the Reference Committee hearing. The complex and awesome nature of the proposed project was acknowledged but its worthiness was cited as an offsetting factor. Various statistics were presented to emphasize the magnitude of the teenage pregnancy problem in Iowa, as well as the related venereal disease problem.

RECOMMENDATION: The Reference Committee recommends adoption of Resolution No. 7, as set forth below, with the insertion of one additional resolved.

Resolved, That the Iowa Medical Society House of Delegates request the Committee on Maternal and Child Health to (a) study the magnitude of the adolescent pregnancy problem in Iowa, (b) prepare a report setting forth circumstances, risks, etc., associated with the problem, and (c) develop recommendations for use by the medical profession, parents, school boards, other educational facilities, and the general public, in dealing with the matter, and be it further

Resolved, That the report of the Committee on Maternal and Child Health be submitted either to the Executive Council or House of Delegates for approval prior to any distribution, and be it further

Resolved, That in its pursuit of this project, the Committee on Maternal and Child Health utilize, at its own discretion, the additional information resources of the State Department of Health, University of Iowa, Planned Parenthood and other such agencies.

Mr. Speaker, I move the adoption of these resolutions.

This concludes the Report of the Reference Committee on Articles of Incorporation and By-Laws and Miscellaneous Business.

K. A. GARBER, M.D., *Chairman*
C. L. DAGLE, M.D.
K. D. DOLAN, M.D.
CHARLES JONS, M.D.
G. L. NELIGH, M.D.

REPORTS OF OFFICERS

Several physicians attended the open hearing of the Reference Committee on Reports of Officers at 2 p.m. on Friday, May 6, 1977, and offered constructive comments and suggestions. The following recommendations are submitted for your consideration and action.

SUPPLEMENTAL REPORT OF BOARD OF TRUSTEES
SECTION I—GENERAL ACTIVITIES

The General Activities report contains information demonstrating the growth in size, service and strength of the Iowa Medical Society, with specific reference to programs designed to assure quality of care, the effective delivery of health care to Iowans, and the inter-relationship of the IMS with such institutions and organizations as the College of Medicine, allied health groups, agencies of state government, and others. Special attention was given to improved communications with the membership.

RECOMMENDATION: The Reference Committee recommends the adoption of the following resolution.

Resolved, That the officers of the IMS be commended for implementing an effective communications program with the membership, which is proving successful in keeping Iowa physicians well informed on current problems confronting the medical profession, and securing the active participation of the membership in helping to resolve them.

Mr. Speaker, I move the adoption of the foregoing resolution.

In response to a directive from the 1976 House of Delegates, based on a resolution from the Polk County Medical Society, the Board of Trustees proposed that a "memorial recognition board" with individual name plates be placed in the IMS headquarters office to honor deceased Iowa physicians selected by the Board to receive special recognition for serving on various boards, councils, and committees of the Society.

Several in attendance at the hearing acknowledged that there are many physicians who serve the IMS with dedication and distinction, but expressed concern about the difficulties in establishing a fair and appropriate mechanism for selecting such individuals for such recognition. The Reference Committee agrees with the principle and intent of the proposal, but feels that establishing a basis for designating recipients of the honor might pose some perplexing problems, and perhaps a more useful and practical method of memorializing physicians could be established.

RECOMMENDATION: The Reference Committee recommends adoption of the following resolution.

Resolved, That the Board of Trustees give further attention to methods of according memorial recognition to deceased members of the IMS who have been active in the affairs of the Society, and report alternative proposals, if any, to the House of Delegates at some future meeting.

Mr. Speaker, I move the adoption of this resolution.

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES SECTION II—FINANCES

Section II of the Board's Supplemental Report comments on various factors considered by the officers in recommending a \$75 dues increase, effective January 1, 1978. The major portion of the reference committee hearing was devoted to a discussion of this proposal. Some of the significant considerations were:

a. The present \$17,000 deficit is primarily the result of inflation, and not the addition of staff members or extraordinary expenses during the past few years.

b. Since the last dues increase in 1974, various economy measures have been instituted, including maintaining the number of staff members at 12 full-time and two part-time individuals—as opposed to a height of 22 staff members some 10 years ago; and reducing in half travel to regional and national meetings by IMS representatives. Officers attending the reference committee meeting advised that the introduction of further economies would not be possible without a subsequent loss in services to the members.

c. The IMS headquarters building, constructed 11 years ago, is in need of repair and refurbishing, and no depreciation funds are available for this purpose. There is

a cash reserve of \$35,000, but this is minimal since most accountants recommend a cash reserve of 50% of the yearly budget.

d. The sale of the lot adjacent to the building, which is also owned by the IMS, was discussed as a possible method of raising funds for the operation of the IMS. This is deemed unwise because of the expected future potential increase in the value of the property, and the possibility of future use by the IMS.

e. The amount of a dues increase was discussed. There was agreement that a \$25 or \$50 increase in dues would not keep pace with inflation, but a \$75 dues increase would undoubtedly provide sufficient financing for the IMS and forestall consideration of another increase for three, and hopefully, four years at least.

f. The committee asked those attending the hearing if they wished to voice any opposition to the dues increase, and there was none. The reference committee also noted that the full report of the Board of Trustees concerning the proposed dues increase was mailed to the entire membership prior to the Annual Meeting, with no resulting letters or resolutions of opposition.

RECOMMENDATION: Recognizing the importance of maintaining a financially sound, aggressive, well-staffed and effective organization to serve the needs of the membership, the following resolution is submitted to you.

Resolved, That IMS membership dues be established at \$275 per member for the year 1978.

Mr. Speaker, I move the adoption of this resolution.

This completes the report of the Reference Committee on Reports of Officers. I wish to express appreciation to the members of this committee—Dr. J. W. White, Dr. G. J. McGowan, Dr. G. J. Hegstrom, and Dr. J. A. Broman—and also to all of the physicians who participated in the discussion during the open hearing.

DON NEWLAND, M.D., *Chairman*
J. A. BROMAN, M.D.
J. W. WHITE, M.D.
G. J. MCGOWAN, M.D.
G. J. HEGSTROM, M.D.

Dr. Caraway introduced the new officers of the Society. The Speaker then asked for new business. Dr. Bliss moved the House of Delegates approve the action of the IMS Board of Trustees from the date of the last previous annual meeting. The motion, as follows, was seconded and adopted:

Resolved, That the actions of the Board of Trustees of the Iowa Medical Society from the date of the last annual meeting be and hereby are ratified and confirmed.

Dr. Bliss commented on the outstanding performance of Dr. James F. Bishop, retiring IMS president, and thanked Dr. Bishop, on behalf of the Society's officers, for the privilege and pleasure of serving with him. The House responded unanimously.

Dr. Caraway announced organizational meetings of the Board of Trustees and Judicial Council would occur immediately following adjournment of the House of Delegates and the installation of Dr. L. W. Swanson as new IMS president. Dr. Swanson addressed the House briefly. The House of Delegates was adjourned at 10:00 a.m.

IOWA MEDICAL SOCIETY

Officers and Committees, 1977-1978

President L. W. Swanson, Mason City
 President-Elect R. S. Gerard, Waterloo
 Vice President R. T. Melgaard, Dubuque
 Secretary W. R. Bliss, Ames
 Treasurer T. A. Burcham, Des Moines
 Speaker of the House of Delegates L. D. Caraway, Amana
 Vice Speaker of the House of Delegates
 J. H. Lohnes, Cedar Rapids

COUNCILORS

	<i>Term</i>	<i>Expires</i>
First District, C. L. Kelly, Jr., Charles City	1979	1979
Second District, W. V. Wulfekuhler, Mason City	1980	1980
Third District, D. F. Rodawig, Jr., Spirit Lake	1978	1978
Fourth District, D. M. Youngblade, Sioux City	1979	1979
Fifth District, D. J. Walter, Des Moines	1978	1978
Sixth District, A. M. Dolan, Waterloo	1979	1979
Seventh District, J. E. Tyrrell, Manchester (Chairman)	1980	1980
Eighth District, R. L. Kent, Burlington	1980	1980
Ninth District, S. A. Smith, Oskaloosa	1980	1980
Tenth District, J. D. Kimball, Osceola	1978	1978
Eleventh District, A. L. Sciortino, Council Bluffs	1979	1979
Twelfth District, E. E. Linder, Ogden	1980	1980

TRUSTEES

J. H. Kelley, Des Moines, Chairman 1980
 A. J. Havlik, Tama 1979
 Hormoz Rassekh, Council Bluffs 1978

DELEGATES TO AMA

Erling Larson, Jr., Davenport December 31, 1978
 J. R. Anderson, Boone December 31, 1979
 J. M. Rhodes, Pocahontas December 31, 1978

ALTERNATE DELEGATES TO AMA

C. H. Denser, Jr., Des Moines December 31, 1978

R. D. Whinery, Iowa City December 31, 1978
 E. B. Mathiasen, Council Bluffs December 31, 1979

EXECUTIVE COUNCIL

L. W. Swanson	Mason City
R. S. Gerard	Waterloo
R. T. Melgaard	Dubuque
W. R. Bliss	Ames
T. A. Burcham	Des Moines
J. H. Kelley	Des Moines
A. J. Havlik	Tama
H. Rassekh	Council Bluffs
C. L. Kelly, Jr.	Charles City
W. V. Wulfekuhler	Mason City
D. F. Rodawig, Jr.	Spirit Lake
D. M. Youngblade	Sioux City
D. J. Walter	Des Moines
A. M. Dolan	Waterloo
J. E. Tyrrell	Manchester
R. L. Kent	Burlington
S. A. Smith	Oskaloosa
J. D. Kimball	Osceola
A. L. Sciortino	Council Bluffs
E. E. Linder	Ogden
Erling Larson, Jr.	Davenport
J. R. Anderson	Boone
J. M. Rhodes	Pocahontas
C. H. Denser, Jr. (non-voting)	Des Moines
R. D. Whinery (non-voting)	Iowa City
E. B. Mathiasen (non-voting)	Council Bluffs
L. D. Caraway	Amana
C. W. Seibert	Waterloo
J. D. Ver Steeg	Des Moines
J. F. Bishop	Davenport

THE JOURNAL

M. E. Alberts Des Moines

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 T. M. Gary Cherokee
 P. J. Leehey Independence
 H. L. Skinner Carroll
 L. W. Swanson Mason City

BLUE SHIELD LIAISON COMMITTEE

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 J. D. Ver Steeg Des Moines
 D. F. Rodawig, Jr. Spirit Lake
 J. H. Kelley Des Moines
 W. R. Bliss Ames
 L. W. Swanson Mason City

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 District 2—G. H. West Mason City
 District 3—E. B. Grossman, Jr. Orange City
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 District 5—John Hess, Jr. Des Moines
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G. R. Clark	Waterloo
J. L. Garred	Whiting
R. S. Gerard	Waterloo
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T. E. Kiernan	Newton
Jose Martinez	Council Bluffs
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T. L. Pester	Council Bluffs
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F. K. Hughes	Des Moines
P. G. Koellner	Ames
H. Kosieradzki	Marshalltown
R. O. McClure	Waterloo
M. R. Moles	Newton
R. C. Smith	Des Moines
R. G. Smits	Des Moines
J. D. Teigland	Des Moines
T. D. Throckmorton	Des Moines
H. F. Trafton	Council Bluffs

*Subcommittee on Medical Practice in
Health Facilities and Homes*

J. F. Veverka	Prairie City
W. G. Dennert	Boone
E. H. DeShaw	Monticello
J. M. Krigsten	Sioux City
C. L. Rask	Maquoketa
D. J. Walter	Des Moines

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L. B. Harned	Waterloo (1978)
K. K. Hazlet	Dubuque (1979)
E. B. Mathiasen	Council Bluffs (1979)
R. A. Manderscheid	Boone (1980)
M. D. Ravreby	Des Moines (1980)
J. G. Rock	Davenport (1979)
D. L. Sweem	West Des Moines (1979)
J. M. Tierney	Carroll (1979)
W. V. Wulfekuhler	Mason City (1979)

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S. E. Ziffren	Iowa City

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A. W. Bostrom, Jr.	Des Moines
L. R. Fane	Mason City
Charlotte Fisk	Des Moines
R. E. Hedican, Jr.	Waterloo
J. L. Kehoe	Davenport
D. O. Newland	Des Moines
E. A. Nitzke	Des Moines
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About IOWA Physicians

Iowa Medical Society president, **Dr. L. W. Swanson**, has been designated by the American College of Physicians to fill an unexpired term in AMA Section Council on Internal Medicine. Dr. Swanson attended a meeting of the Council in San Francisco in June. **Dr. H. L. Vander Stoep**, Le Mars physician for 40 years, closed his office July 1. **Dr. Jose V. Angel**, Council Bluffs, was elected a fellow of the American College of Allergists. **Dr. L. O. Ely**, Des Moines, was the guest speaker at a recent Simpson College student forum in Indianola. Dr. Ely's topic, "The Quality of Life." **Dr. Fred G. Smith**, professor and head of Department of Pediatrics at U. of I. College of Medicine, received the 1977 School of Medicine Alumni Professional Achievement Award from the University of California, Los Angeles (UCLA). The award is presented to an alumnus for noteworthy contributions to medicine and medical education. **Dr. E. M. Mumford**, Sioux City, was named president of St. Luke's Medical Center medical staff. Other officers elected were—**Dr. S. W. Leafstedt**, vice president and **Dr. J. L. Bristow**, secretary-treasurer. **Dr. Walter B. Eidbo**, Des Moines, was the guest speaker at recent meeting of United Ostomy Association, Des Moines, Iowa Chapter. Dr. Eidbo's topic, "All About Colostomy and Ileostomy." **Dr. Mangil Seo** has opened an office in Des Moines for the private practice of general surgery.

Dr. A. R. Swearingen, Bettendorf, was elected president of the medical staff of St. Luke's Hospital in Davenport. Other officers are—**Dr. J. H. Smith**, Davenport, vice president, and **Dr. R. J. Byrum**, Davenport, secretary-treasurer. **Dr. Mark A. Stewart**, head of the Child Psychiatry Division at University Hospitals, was the guest speaker at a recent meeting of the Mental Health Association of Polk County. **Dr. Howard E. Rudersdorf**, Sioux City, received the Iowa Heart As-

sociation's Outstanding Volunteer Award at a meeting of the 24-county Northwest Division of IHA. Dr. Rudersdorf was cited for his volunteer work at the county and state levels. **Dr. Don E. Boyle**, Sioux City, president of the Northwest Division, presented the award. **Dr. Robert Hardin**, Dean of the U. of I. College of Medicine, was re-elected vice president, Research, at the annual meeting of American Diabetes Association, Iowa Affiliate. **Dr. Gerald F. DiBona**, professor and vice chairman of Department of Internal Medicine at U. of I. College of Medicine, was named president-elect of the American Federation for Clinical Research. Dr. DiBona is currently president of the Kidney Foundation of Iowa. **Dr. L. W. Swanson**, Mason City, IMS president, is the recipient of the U. of I. College of Medicine Distinguished Service Award. The award was presented to Dr. Swanson during recent Alumni Reunion week end. **Dr. Thomas W. Hepperlen**, Sioux City, received first prize for new ureteral stent exhibited at annual meeting of American Urological Association in Chicago.

Dr. William D. DeGravelles, Jr., Des Moines, director of the Physical Medicine Department of Iowa Methodist Medical Center, has been named National Public Citizen of the Year by the National Association of Social Workers. The award was presented to Dr. deGravelles at the annual forum of the National Conference on Social Welfare in Washington, D. C. **Dr. James A. Clifton**, president of American College of Physicians and Roy J. Carver professor at U. of I. College of Medicine, and **Eldon E. Huston**, executive vice president of the Iowa Medical Society, were among the program participants at a recent meeting of the Iowa Region of American College of Physicians and Iowa Clinical Society of Internal Medicine. **Dr. L. W. Swanson**, Mason City, IMS president and ACP Governor for Iowa, and **Dr.**

James L. Knott, Council Bluffs, president of the Iowa Clinical Society of Internal Medicine, were in charge of the Iowa regional meeting. **Dr. William B. Bean**, Galveston, Texas, former chairman of the Department of Medicine at U. of I. College of Medicine, was a guest of honor. Sioux City physicians, **Drs. John Baller, Michael Chandra, Dennis Wright, Walter Eckman**, and **Alf Jordan**, participated in a recent medical seminar in Sioux City. **Dr. Herman Hein**, assistant professor in Department of Pediatrics at U. of I. College of Medicine, also addressed the group. His topic "Perinatal Care." **Dr. John R. Parish**, retired Grinnell physician, was the honorary marshall at commencement exercises at Grinnell College. A Grinnell graduate, Dr. Parish received the M.D. degree at Harvard University and began his practice of medicine in Grinnell in 1933.

Dr. John K. MacGregor, Mason City, received an Alumni Achievement Award during commencement ceremonies at Cornell College. Dr. MacGregor, a 1941 Cornell graduate, served on the College's board of trustees from 1964 to 1973. **Dr. John Kuncaitis** has joined the Wiltfang-Paulson Clinic in Grinnell. Dr. Kuncaitis received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Broadlawns Hospital in Des Moines. **Dr. David T. Kaung**, Des Moines, was named recipient of the American Lung Association of Iowa, Walter L. Bierring Award, for medical advancement in fighting lung disease.

DEATHS

Dr. Abbott M. Dean, 76, Council Bluffs, died May 11 at his home. Dr. Dean received the M.D. degree at Harvard University and completed postgraduate training at the Eye and Ear Infirmary in Boston, Massachusetts. He was a member of American College of Ophthalmology, past president of Rotary Club and veteran of World Wars I and II.

Dr. Barclay J. Moon, 82, former Cedar Rapids resident and retired surgeon, died May 3 in a Davenport hospital. Dr. Moon received the M.D. degree at U. of I. College of Medicine and began his practice of surgery in Cedar Rapids in 1924. Dr. Moon was a member of American College of Surgeons, Iowa Clinical Surgical Society, and past president of Linn County Medical Society.

Morbidity Report for May, 1977

Disease	May 1977	1977 to Date	1976 to Date	Most May Cases Reported From These Counties
Amebiasis	11	36	26	Boone
Chickenpox	665	7098	9320	Linn, Polk, Scott
Conjunctivitis	277	1610	1387	Scattered
Encephalitis				
viral	1	3	—	Iowa
type unspecified	1	1	2	Calhoun
Erythema infectiosum	12	47	138	Cerro Gordo, Johnson
Gastrointestinal				
viral infection	1298	15845	16079	Davis, Lee, Madison
Giardiasis	4	30	15	Black Hawk, Mills
Hepatitis				
A infectious	14	46	57	Ida, Polk
B serum	20	53	39	Buchanan, Dickinson, Polk
type unspecified	3	10	9	Buchanan, Jefferson
Impetigo	64	364	468	Lee, Woodbury
Infectious mononucleosis	100	645	628	Scattered
Influenza—lab confirmed	3	68	154	Johnson
Influenza-like illness	1725	40036	39102	Humboldt, Monona
Meningococcal meningitis	3	4	9	Delaware, Henry, Sioux
Meningitis, aseptic	2	3	—	Howard, Johnson
Mumps	83	1227	1135	Black Hawk, Delaware
Pediculosis	89	203	249	Scott
Pinworms	2	22	10	Polk
Pneumonia	75	525	650	Scott
Rabies in animals	16	53	50	Scattered
Rheumatic fever	3	25	16	Allamakee, Jones, Lee
Ringworm				
body	22	174	161	Scattered
scalp	1	5	18	Kossuth
Rocky Mountain Spotted Fever	1	1	3	Iowa
Rubella (German measles)	35	157	39	Johnson
Rubeola (measles)	1082	3855	29	Black Hawk, Johnson, Polk
Salmonellosis	30	75	48	Scott
Scabies	56	539	400	Polk, Warren
Shigellosis	2	17	29	Dubuque, Johnson
Streptococcal infections	1059	7841	9868	Dubuque, Johnson
Tuberculosis				
total ill	14	74	47	Scattered
bacteria positive	9	32	42	Scattered
Venereal diseases				
gonorrhea	363	2261	2670	Black Hawk, Polk, Scott
syphilis	27	158	142	Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
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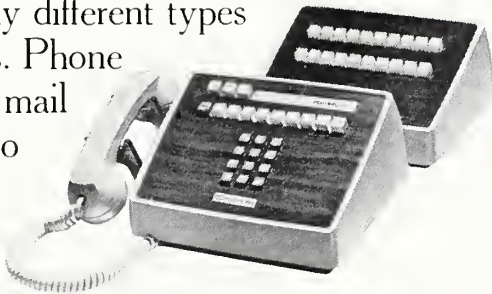
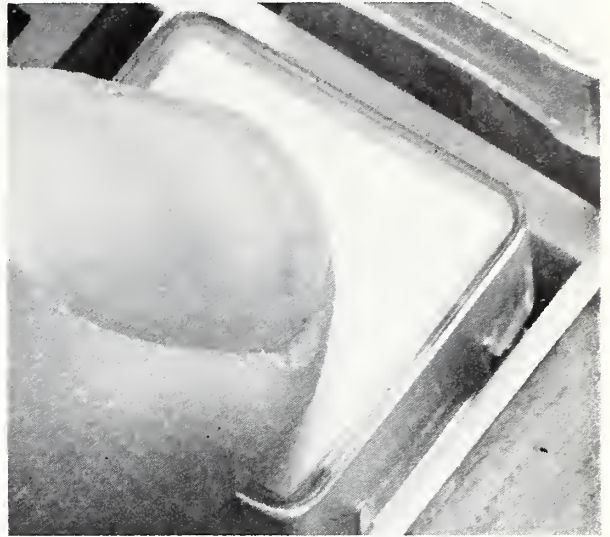
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FOR SALE—Every office reception room should have a copy of "Unseen Battles of the Night" by S. W. Barnett, M.D., Cedar Falls, Iowa. Send check for \$7.50 to Box 485, Cedar Falls, Iowa 50613 and a copy will be sent postpaid.

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IOWA Medical Miscellany

EXAMINERS . . . Des Moines pathologist Alexander Ervanian, M.D., has been named to a three-year term on the State Board of Medical Examiners. Rosalie Neligh, M.D., Council Bluffs, and John M. Rhodes, Sr., M.D., Pocahontas, have been reappointed for similar periods. Dr. Rhodes serves as Board chairman.

LIABILITY PROGRAM . . . Participants in the IMS/Aetna Liability Insurance Program have surpassed the 350 level. Inquiries about the coverage are continuing to be received. Information continues to be available either from the IMS Headquarters (515-223-1401) or from the Des Moines Aetna office (1/800-362-1809). The IMS Medico-Legal Committee met July 27 to receive a status report on the program and to conduct an insurability hearing.

TEENAGE PREGNANCY . . . The IMS Maternal and Child Health Committee met July 21 to determine how it will conduct the study of the teenage pregnancy problem as requested by the 1977 House of Delegates. Use of several outside sources of expertise is expected.

MENTAL HEALTH STUDY . . . A Washington, D. C., firm, Human Services Research Institute, has been selected to conduct a study of Iowa's mental health services. The study is funded (\$75,000) through an appropriation of the 1977 General Assembly. In addition, a 9-member Governor's Task Force (includes two physicians) is undertaking a mental health study. The two projects will be non-duplicative to the extent possible and cooperative in nature.

STAY IN IOWA . . . Twenty of 38 third-year family practice residents in 5 FPR programs (Broadlawns and Iowa Lutheran in Des Moines, Cedar Rapids, Iowa City, and Davenport) have opted to continue their medical careers in Iowa.

LEGISLATION SIGNED . . . Among bills signed by Iowa Governor Ray in July was the certification of need proposition which requires any new or changed institutional health service to have a CON. Various conditions apply, e.g., a CON is needed to purchase or acquire any single item of equipment in a physician's office which exceeds \$150,000 in cost. A 5-member council is to be named by the Governor before October 1 and will be responsible for making decisions on CON applications. No providers can serve on the Council. The program is to be administered by the State Department of Health.

MORE LEGISLATION . . . Also signed in July by the Governor was legislation to require the various state licensing boards to instigate programs of continuing education as a condition of licensure. The State Board of Medical Examiners will continue to confer with the IMS on the best way to implement this law.

HEALTH SYSTEMS PLAN . . . The draft of a Health Systems Plan is set for public scrutiny in August. The Plan is a federal requirement which the Iowa Health Systems Agency must prepare. Eleven August meetings will occur across the state to brief interested persons regarding the plan. Meetings are scheduled August 10—Spencer (7 p.m., Clay County Bank) and Ft. Dodge (7:30 p.m., Iowa Central Community College); August 11—Waterloo (7 p.m., Recreation and Arts Center), Sioux City (7 p.m., Howard Johnson's) and Carroll (7:30 p.m., IPS Community Room); August 16—Calmar (7 p.m. Area I Community College) and Creston (8 p.m., Southwest Community College); August 17—Clear Lake (7 p.m., Municipal Building) and Cedar Rapids (7 p.m., Linn County Health Center); August 18—Mt. Pleasant (7 p.m., Henry County Savings Bank); August 19—Des Moines (10 a.m., Olmsted Center, Drake University). Physicians are urged to attend the briefing in their areas.

The Question Box



by JOHN H. BRINKMAN, M.D.

IFMC/PSRO

John H. Brinkman, M.D., Mason City, became president of the Iowa Foundation for Medical Care earlier this year. He comments on its current status here.

Can you describe briefly the benefit of the Foundation to the profession and the public?

The public and the profession are obviously concerned about the increasing cost of medical care. Those of us in the health care delivery system know most of the costs are justified. We know too the profession and its patients do not benefit when government or third-party payers arbitrarily establish cost control policies. The Foundation peer review program permits the profession to apply cost effective measures through a system operated by physicians. If there are cost savings to be realized they will come about through proper application of peer review and physician concern for the welfare of the patient.

Is the Foundation serving and maturing in line with the wishes of the IFMC leadership?

The IFMC was established by Iowa physicians to promote and encourage the delivery of quality medical care in an appropriate amount and at a reasonable cost. We believe we are fulfilling this general objective. Through a system of concurrent review, we are seeing a reduction in admission rates and lengths of stay. This has not affected the quality of care being delivered. The IFMC is addressing quality assurance through the performance of medical care evaluation studies. These studies are on specific topics and

provide medical staffs feedback on the quality of care being delivered in the institution. This then becomes a tool for determining continuing medical education needs.

Have physicians been generally supportive as PSRO has been phased in?

Physicians have become more supportive and comfortable with PSRO as they have become aware of the methods of review which are being utilized. The IFMC has tried to minimize outside interference through delegation and reliance on local medical staff performance of the review. This reduces much of the bureaucracy and results in more effective review.

Is the Foundation on schedule in its implementation of the PSRO program?

Yes, we are on schedule if you consider the number of admissions now under PSRO review. Currently, the IFMC has provided delegated status to 53 Iowa hospitals. These represent approximately 74% of the total admissions in the state. In terms of number of hospitals, we are not working with as many as we would like. Over 60% of the hospitals have yet to enter into some type of agreement with the IFMC to perform review. The IFMC desires to delegate review to as many hospitals as possible. This means providing a significant amount of technical assistance to the hospitals to bring their programs in line with criteria necessary for them to become delegated. We believe most all hospitals will be involved with PSRO review by the end of this year.



SCIENTIFIC ARTICLES

Aggressive Regional Therapy of Melanoma Involving the Extremity

PETER R. JOCHIMSEN, M.D., and

RICHARD L. LAWTON, M.D.

Iowa City

THE PHYSICIAN faced with treating the patient with recurrent melanoma, or the patient with widespread disease, experiences a profound sense of frustration as he watches the inexorable progression of the disease process. As in the treatment of virtually all cancers, the opportunity for cure is maximized at the first encounter and failure is frequently associated with the secondary effort.

Malignant melanoma, the black cancer, no longer deserves its previous reputation as a killer. If this tumor is diagnosed early and treated appropriately, cure is the rule rather than the exception.

Since chemotherapeutic hyperthermic isolated perfusions of extremities have been demonstrated to be important adjuncts to the treatment of advanced cancers,¹ it seems appropriate that a trial be conducted evaluating this modality in individuals with "early" melanomas—the purpose of

Dr. Jochimsen is an assistant professor in the Department of Surgery at the University of Iowa College of Medicine. Dr. Lawton was a professor in the U. of I. Department of Surgery and has since become associate chairman of the Department of Surgery at Texas Tech University in Lubbock, Texas.

Evaluation is made here of hyperthermic chemotherapeutic perfusions to assess the procedure as a prophylactic agent in conjunction with adequate surgery. The authors express enthusiasm over the potential.

such an effort being sterilization of residual microscopic foci of tumor cells in the extremity.

Such a trial is currently in progress at the University of Iowa Hospitals and Clinics.

HISTORY

It was Klopp² who suggested in the early 1950's that chemotherapeutic agents could be delivered effectively through the intra-arterial route to various tumors. Later in that decade, Creech³ described isolation perfusion of extremities utilizing the then recently developed pump oxygenator to give high dose chemotherapy in extremity malignancies.

Krementz⁴ reported in 1972 the results of a 14-year clinical experience using extremity perfusion with L-Phenylalanine mustard. It has been the impression of the authors that chemotherapy by perfusion as an adjunct to conventional excisional surgery in localized or Stage I disease added approximately 15% to the five-year survival rates for invasive melanoma. Patients with

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS
THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF AUGUST 1977.

regional or Stage II disease were believed to have a doubling of survivorship.

With the laboratory confirmation that certain tumor cell lines were selectively more sensitive to heat than normal tissues,⁵ a logical progression of isolation perfusion application was the addition of temperature elevation. Stehlin,¹ in Houston, has recently reported on his series of patients with malignant melanoma of the extremities treated by the addition of heat to regional perfusion with L-Phenylalanine mustard and concludes there has been a "dramatically improved objective response of melanoma." This agent was synthesized with the expectation it would be particularly useful in the treatment of melanoma since Phenylalanine is a metabolite of melanin and would carry cytotoxic alkylating radicals into melanin-producing tumor cells.

PATIENT POPULATION UNDER STUDY

Good correlation has been demonstrated between the histologic staging of the primary lesion according to the method of Clark⁶ (Figure 1) and the incidence of recurrence, nodal metastases at time of elective node dissection and the post-surgery five-year disease survival. Wanebo,⁷ in reviewing the material from the Memorial Sloan Kettering Cancer Center, found the five-year disease-free survival after surgery was 100% for Clark level II, 88% for level III, 66% for level IV, and 15% for level V. In an effort to improve these statistics, a prospective trial is currently in progress at the University of Iowa Hospitals and Clinics treating all patients with Clark level II lesions (invasion of the papillary dermis) and deeper, employing chemotherapeutic hyperthermic perfusions in association with regional nodal dissection, wide excision and split thickness skin grafting of the primary site.

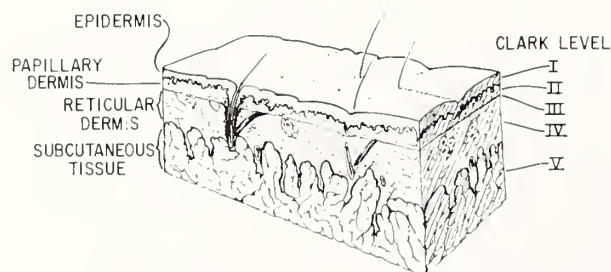


Figure 1. Cross section of dermis—epidermis with Clark's levels indicated.

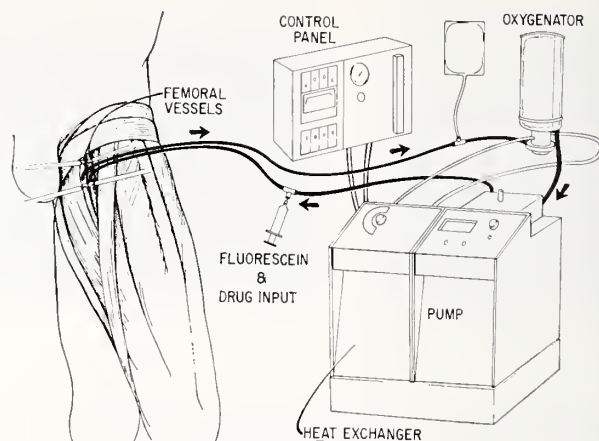


Figure 2. Extremity and perfusion apparatus presently utilized, schematically portrayed.

TECHNIQUE

Patients have been referred to this institution after having undergone incisional or excisional biopsies by their referring physicians. The clinical status of each patient is identified in the usual manner with electrocardiograms, chest films, examination of the primary site, regional lymph node evaluation, and occasionally with lymphangiograms and evaluation of urinary melanogen excretions. Previously obtained microscopical slides are evaluated to demonstrate the lesion is indeed a melanoma and it does extend deep into the papillary dermis or beyond.

In the operating room under general anesthesia the patient is prepared with the appropriate extremity and regional lymph-bearing area well draped into the field (Figure 2).

The appropriate vessels are surgically exposed, usually the femoral in the lower extremity and the brachial in the upper; the patient is systemically heparinized and the vessels cannulated. The cannulas are then connected to a pump oxygenator. A tourniquet is applied above the entrance of the catheters and the extremity is placed on bypass. Banked whole blood is used to prime the pump and start the perfusion. Perfusate is heated to 40° C and, when good flow is established, 2 cc of fluorescein dye are injected into the arterial cannula and the extremity is checked with a Wood's lamp to demonstrate the perfusion's extent. The skin proximal to the tourniquet's level is examined to assure that there is no evidence of a leak, and the sclera of the eyes are carefully checked for evidence of fluo-

rescing. If leakage and fluorescing are not discovered, lower extremities are perfused with 1 mg/kg body weight of L-Phenylalanine mustard. Upper extremities receive 0.8 mg/kg body weight. This amount of drug is given in two divided doses, one at the institution of the perfusion and the other 30 minutes later. One hour following the initial institution of the chemotherapeutic agent, with the perfusate constantly kept at 40° C, the venous effluent is discarded and 500 cc of low molecular weight Dextran is then administered. At the conclusion of this the venous effluent is relatively clear and a second unit of bank blood is given. The catheters are then removed and the vessels are repaired with fine interrupted silk sutures. The tourniquet is removed and the patient resumes perfusion of the extremity.

A superficial groin dissection or an axillary dissection is then performed, as appropriate to the individual case. This is followed by a wide excision, usually obtaining at least a 3-4 cm margin around the lesion, which is carried deep to and including the underlying fascia of the initial tumor site. A split thickness skin graft is placed over the created defect.

NUMBER OF CASES

Twenty-one prophylactic perfusions have been performed at the University of Iowa Hospitals and Clinics since April of 1975 (Table 1). There have been 13 female and 8 male perfusions. Fourteen lower extremities and seven upper extremities were perfused. The level of histologic invasion of the primary lesion in this group is 7 patients with level III lesions, 11 patients with level IV lesions and 3 patients with level V lesions. No patients with level I or level II lesions were included in this prospective study on evaluation of the effectiveness of hyperthermic chemotherapeutic perfusions. All of the patients had, in conjunction with their perfusions, regional node dissections. The average number of nodes recovered in the groin dissections when nodes were counted was 12.1, while in the upper extremity axillary dissections the number was 12.3. Three of the patients had positive nodes recovered, 5 out of 15 in an axillary dissection in a man with a level V lesion, 2 out of 16 in a male with a level V leg lesion, and 1 out of 13 nodes in a female with a level IV leg lesion were positive.

While followup has been limited, only one pa-

TABLE 1
DEMOGRAPHIC INFORMATION OF 16 PATIENTS
TREATED TO DATE

Patient	Age	Sex	Location*	Clark's Level	Nodes	Date
M.D. . .	52	M	L.L.	V	2/16	4/30/75
W.M. . .	49	F	L.L.	IV	0/?	6/25/75
D.C. . .	44	M	L.L.	V	0/14	6/27/75
R.S. . .	32	M	L.L.	IV	0/?	7/09/75
G.E. . .	53	F	L.L.	III	0/9	8/01/75
E.G. . .	60	F	L.L.	IV	0/15	9/04/75
J.S. . .	53	F	L.L.	III	0/13	1/04/76
R.S. . .	45	M	R.U.	IV	0/19	3/10/76
S.T. . .	28	F	R.L.	IV	0/9	3/19/76
M.S. . .	20	F	R.U.	IV	0/8	3/24/76
L.J. . .	60	M	R.U.	V	5/15	4/14/76
S.H. . .	54	F	R.L.	IV	0/?	4/15/76
A.G. . .	41	F	R.L.	III	0/?	4/19/76
S.D. . .	53	F	R.L.	III	0/11	5/14/76
G.T. . .	64	F	L.L.	IV	0/16	5/19/76
E.D. . .	69	F	L.L.	IV	1/13	5/24/76
F.D. . .	50	F	L.U.	IV	0/8	7/26/76
W.G. . .	55	M	R.U.	III	0/20	8/03/76
A.M. . .	47	M	L.U.	III	0/5	10/04/76
H.M. . .	62	F	R.U.	IV	0/10	10/11/76
D.D. . .	57	M	R.L.	III	0/7	2/10/77

* L.L. = left lower
R.L. = right lower
R.U. = right upper
L.U. = left upper

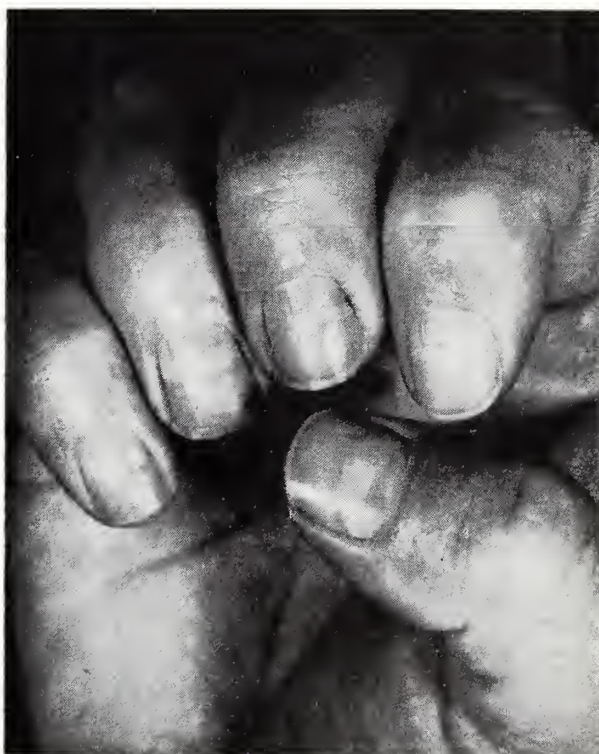


Figure 3. Three months following therapy the nails of the hand are growing out.



Figure 4. Toe nails demonstrating cessation of growth followed by regrowth.

tient, L.J., a man with a level V lesion and 5 of 15 positive axillary nodes, has developed pulmonary metastasis 9 months following the procedure. In a sense this patient was not a prophylactic perfusion since he did have clinically positive nodes when initially seen.

From another retrospective study⁶ one can predict that 35% of patients with level III lesions will succumb with a median survival of 2.1 years, 46% of patients with a level IV lesion will die with a median survival of 2.25 years, and 52% of patients with a level V lesion will be dead of their disease with a median survivorship of 1.83 years.

Since the median survivorship for these lesions is approximately two years, one can conclude from this data that, if there are no recurrences in that period of time, the current regimen employing perfusion plus elevated temperature in conjunction with wide excision and regional node dissection is an important adjunct in the treatment of this disease.

MORBIDITY

It is obvious that a study such as this can be undertaken only with the understanding and appreciation that a certain morbidity and even the possibility of mortality may be resultant consequences of the therapy. To date no mortalities have occurred, no patients have suffered from vascular damage attendant upon the arteriotomy and venotomy, and the major factor of morbidity is related to postoperative edema. This edema most likely relates to the node dissection and tends to be most prominent in the immediate postoperative period with resolution as time pro-

gresses. In no patients has this been disabling and, indeed, most patients do not even wear support hose, though it is recommended in the immediate postoperative period.

There is one patient who has a resolving neurological deficit of some weakness in finger flexion. This patient was treated in March of 1976 and is improving rapidly. She was perfused via the subclavian vessels and there is some thought that the brachial plexus may have been traumatized at the time of the perfusion.

No other morbidity has occurred save some delayed wound healing related to the groin dissections. No patients have required skin grafting of the groin dissections, and only one patient required regrafting of the initial wide excision site due to failure of the graft to take satisfactorily.

The technique of perfusion of body parts allows for the introduction of high doses of cytolytic drugs to a specific region of the body. Such perfusion, with subsequent "washing out" prior to reestablishment of the normal circulatory pattern, spares the other tissues most commonly as-



Figure 5. Decreased hair on lower extremity months following perfusion.

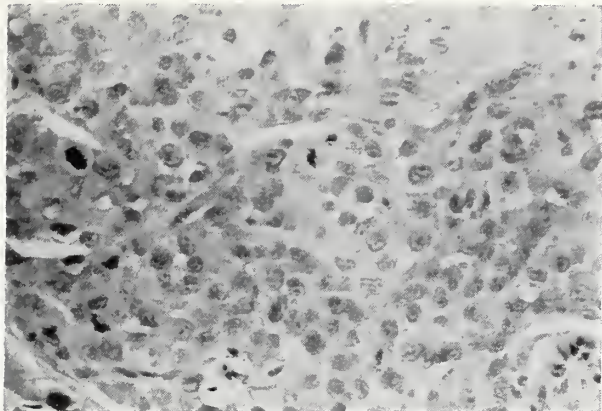


Figure 6. Highly cellular malignant melanoma seen prior to perfusion.

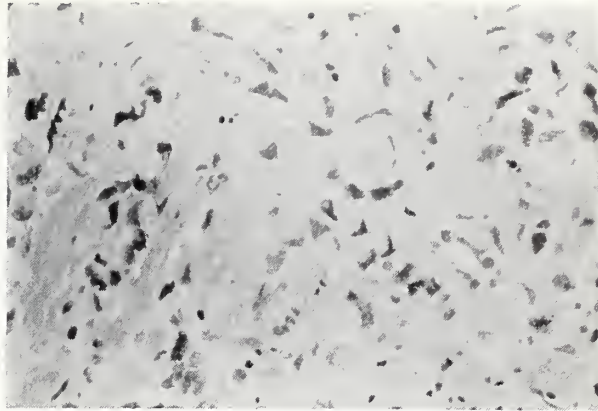


Figure 7. Increased fibrosis and decreased cellular activity 6 weeks following perfusion.

sociated with systemic toxicity. Thus, the bone marrow, the GI tract, and the rest of the body's hair follicles are not depressed. Evidence of localized toxicity, presumably related to the chemotherapeutic agent, has been well documented in several of our patients. An obvious cessation of the nail beds' growth has occurred in patients (Figures 3, 4) and most patients have noticed a failure to regrow the same amount of hair on the perfused extremity as compared with the opposite side (Figure 5).

In another patient, not in the group here reported, preperfusion and delayed biopsy of in-transit metastasis following perfusion, revealed marked alteration in the tumor histology (Figures 6, 7), demonstrating that grossly recognizable tumor is susceptible to the therapy.

DISCUSSION

Recurrence of an invasive malignant melanoma is virtually pathognomonic of future widespread disease and ultimate death. While currently many modalities are being evaluated in terms of reducing recurrence from this disease, includ-

ing immunologic manipulation, adequate surgery still remains the hallmark of cure. To this end, it seems appropriate to continue evaluating hyperthermic chemotherapeutic perfusions to assess its role as a prophylactic agent in conjunction with adequate surgery.

While one is unable to definitely state that this technique will result in improved cures, as of this writing, one can certainly remain enthusiastic about the potential.

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MEDICAL MISCELLANY

MOBILE HEALTH SCREENING . . . Representatives of the Society met July 13 with officials of Farmland Coop to go over the revised health screening program now being pursued in Iowa by Farmland. Emphasis was again placed on the importance of advising the local medical community before any screening activity is commenced.

OVERRIDE MAC . . . Maximum Allowable Cost (MAC) limitations may be established by the federal government for certain multiple source drugs. However, where a physician properly indicates a MAC limitation may be rendered inoperative for a particular patient. Such an order must be in the physician's handwriting on a prescription blank or attached separate sheet. A standard phrase (brand necessary) can be used but may not be printed on the blank; neither is a rubber stamp permitted.

Distribution of Primary Care Physician's Assistants in the State of Iowa

DENIS R. OLIVER, Ph.D.,

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JOHN J. GERSTBREIN, R.P.A., and

NANCY WOMBACHER, B.S.

Iowa City

A FORMAL EDUCATIONAL PROGRAM to train the primary care physician extender* was first established in 1965 when Eugene Stead, M.D., then Chairman of the Department of Medicine at Duke University, initiated a pilot program to train "physician's assistants."¹ Stead believed many repetitive, time-consuming yet technical tasks associated with medical practice could be delegated to properly trained medical assistants.² This was considered one way to alleviate some problems facing the health care delivery system, including the maldistribution of physicians, the spiraling cost of both medical education and medical care, the increasing physician specialization and the inefficient utilization of the physician.^{3, 4}

In the past decade there has been a dramatic increase in the number of physician's extender training programs. This is partly due to the infusion of funds from the Bureau of Health Manpower Education of the National Institutes of Health. Currently there are 46 educational programs for PA's which have been approved (accredited) by the Council on Medical Education of the American Medical Association.⁵ A majority of these programs are at the baccalaureate level and are associated with Schools of Medicine or

A survey of Iowa-employed physician's assistants is analyzed. The geographical distribution, classification of the type of practice and employer, and community size are shown for graduates of the PA program at the University of Iowa and for those PA's graduated from other programs. Findings show (a) a majority of the Iowa graduates are in the state; (b) nearly half are in primary care settings in communities under 20,000 population, and (c) the distribution pattern of Iowa graduates appears similar to those who have graduated from other programs.

Allied Health Sciences. They are commonly 24 months in length, ranging from 12 to 45 months.

On the average, approximately 1,500 PA's are graduated each year. Upon graduation from an AMA-approved program, graduate physician's assistants may sit for the National Certification Examination for Assistants to the Primary Care Physician, administered by the National Board of Medical Examiners. First given in 1973, to date approximately 4,000 have successfully completed the examination and are identified as *Physician's Assistants—Certified*. Over the last three years, graduates of the Iowa program have consistently performed in the upper 10% of all those sitting for the certification examination, placing the program fourth (1974), third (1975) and second (1976) nationally.

LIABILITY THREAT

Although originally thought to be of major concern it is likely that there is a reduction in malpractice risk when a certified PA is incorporated into a medical practice. This is probably due to the fact that physician's assistants allow the physician to concentrate on more complicated medical problems only he can manage, increasing patient satisfaction and reducing errors. In addition,

* A generic term including MEDEX, child health associate, surgeon's assistant, physician's associate and assistant and primary care associate.

Dr. Oliver is Director of the Physician's Assistant Program at the University of Iowa College of Medicine. Dr. Laube is Medical Director, John Gerstbrein is Clinical Coordinator, and Nancy Wombacher is Program Assistant of the Physician's Assistant Program.

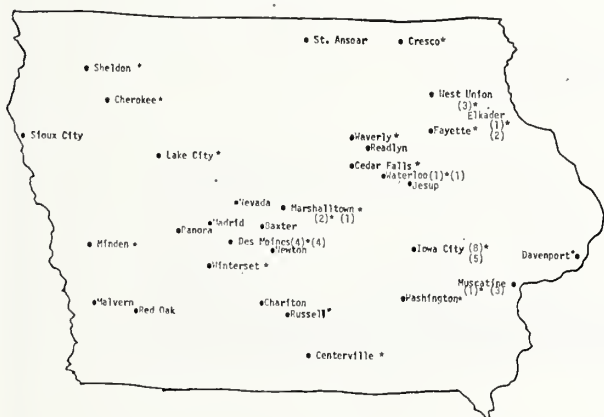
many studies have shown in practices employing PA's, patient waiting periods are reduced, patients receive greater attention, and the overall quality of medical care is improved.⁶⁻⁹

As to deployment patterns, according to a recent survey of 1,500 practicing PA's conducted by the Association of Physician's Assistant Programs (APAP), 77% are employed in primary care settings in communities with populations less than 20,000, usually in solo or group practices. They are distributed over the country with the northeastern, southern and southwestern regions showing the greatest concentration.

U. OF I. PROGRAM

In 1972, the PA program at the University of Iowa College of Medicine accepted its first class

Figure 1
GEOGRAPHICAL DISTRIBUTION
of PHYSICIAN'S ASSISTANTS IN IOWA



of 10 students. In an earlier publication the rationale was presented for establishing the Iowa PA program, along with a description of the two-year curriculum and a summary of the certification and registration procedures necessary for employment in Iowa as a physician's assistant.¹⁰ At that time the major program goals were to train persons to assume a high degree of responsibility in primary health care under the physician's direction and supervision and to deploy these individuals to areas of greatest need. To measure the level of success we surveyed Iowa program graduates employed in Iowa as physician's assistants. In addition, we assayed a majority of the non-Iowa graduate PA's employed in Iowa to see whether the state showed a distribution of PA's similar to that seen nationally. For the purposes of this study, only type-A physician's assistants (based on the classification defined by

TABLE 1

LOCATION OF GRADUATES OF THE PHYSICIAN'S ASSISTANT PROGRAM AT IOWA BY STATE			
Iowa	35	Missouri	1
Wisconsin	1	Indiana	1
Illinois	2	Oregon	1
Minnesota	1	New York	1
South Dakota	1	Foreign	1
Total			45

the National Academy of Sciences)¹¹ were surveyed. The following describes in a general way the duties and level of responsibility of the type-A physician's assistant:

The physician's assistant is qualified to collect, organize, and present patients' historical and physical data so that the physician can determine appropriate action; to assist the physician in the performance of clinical procedures; and to coordinate the functions of auxiliary personnel. Typically, the primary-care physician's assistant is involved in such areas as diagnostic services, care of acute disease and injury, rehabilitation, special medical services, continuing medical care for chronic disease and pregnancy, health maintenance, and community health services. While working under the general supervision and responsibility of the physician, the physician's assistant must be able to exercise a degree of independent judgment requiring an ability to integrate and interpret findings on the basis of general medical knowledge.

As of June, 1976 the PA program at the University of Iowa has graduated 45 persons; class of 1974—10, 1975—17 and 1976—18. Table 1 summarizes the present location of these graduates by state. Eighty percent (36) of these people have remained in Iowa where all but four are currently employed as physician's assistants. It is noteworthy that 91% have remained in the Midwest with an Iowa graduate represented in all but one of the contiguous states. One person is working as a PA in a foreign country. These data indicate that students tend to remain in the area in which they are trained, an observation which has been made elsewhere.¹² Subsequent data relative to place of employment tends to support this contention (*vide infra*). Figure 1 shows the geographical distribution of Iowa and non-Iowa pro-

gram graduates. This figure demonstrates the widespread distribution of PA's throughout the state, many of whom are situated in small rural Iowa communities with populations less than 5,000. There is a concentration of PA's in both Des Moines (7) and Iowa City (13) where the primary employers are the Veteran's Administration Hospital and the University of Iowa Hospitals and Clinics, respectively.

RELATION TO POPULATION

Table 2 shows the distribution of physician's assistants employed in Iowa with respect to community population. Eighty-five percent of the

TABLE 2
LOCATION OF PHYSICIAN'S ASSISTANTS BY
COMMUNITY POPULATION

Community Population	U. of I.		Total	(%)
	Program Graduate	Non-Iowa Graduate		
5,000 or under	10	8	18	(31)
5,000 to 10,000	4	2	6	(10)
10,000 to 20,000	0	1	1	(2)
20,000 to 50,000	13	9	22	(37)
50,000 to 100,000	1	3	4	(7)
Over 100,000	4	4	8	(13)
Total	32	27	59	(100)

Iowa graduates are employed in communities with a population less than 50,000 and 44% are in communities of 10,000 or less. This pattern is also seen when non-Iowa graduate physician's assistants employed in the state are compared (Table 2, column 2). It is particularly noteworthy that nearly one-third of all PA's are employed in rural communities where it may be conjectured there is the greatest need.

Inspection of Tables 3 and 4 shows a majority of PA's are employed in family (general) medicine in either solo or group practices. Fifty-three percent of the Iowa PA program graduates and 70% of the non-Iowa graduates are working in family practice. Other physicians in specialties such as obstetrics/gynecology, pediatrics, general surgery and internal medicine are also employing PA's. Four PA's are currently in positions of administration or research at the University of Iowa College of Medicine. The largest employers of Iowa PA's are the Veteran's Administration Hospitals in Des Moines and Iowa City and the University of Iowa Hospitals and Clinics. To-

TABLE 3
CLASSIFICATION OF TYPE OF PRACTICE
EMPLOYING PHYSICIAN'S ASSISTANTS

	U. of I.		Total	(%)
	Program Graduate	Non-Iowa Graduate		
General/family practice	17	19	36	(61)
Surgery	2	0	2	(3)
Internal medicine	4	0	4	(7)
Obstetrics/gynecology	2	0	2	(3)
Pediatrics	1	0	1	(2)
Administration/research	2	2	4	(7)
Industrial	0	1	1	(2)
Other	4	5	9	(15)
Total	32	27	59	(100)

gether these institutions employ a quarter of the state PA's and a third of the Iowa program graduates. With respect to the Iowa graduates this trend may reflect the fact that a relatively large number of the required and elective clinical rotations during the second year of training are completed at these institutions—thus increasing the exposure to the staff at these facilities of the capabilities of this type of health care professional and enabling the student PA to gain access to potential employment opportunities upon graduation. The employment record of non-Iowa graduate PA's working in the state appears to support this observation as there are none employed in the Iowa V.A. hospitals.

FUTURE TRENDS

The Iowa PA program has recently re-examined the clinical curriculum with respect to the preceptorships and the clinical training sites of the PA students. From this self-analysis specific needs have been identified including: (1) a need to en-

TABLE 4
TYPE OF EMPLOYER

	U. of I.		Total	(%)
	Program Graduate	Non-Iowa Graduate		
Private/solo	7	8	15	(25)
Group/partnership	9	7	16	(27)
Clinic/hospital	6	6	12	(20)
Government hospital	8	0	8	(14)
University/college	2	5	7	(12)
Other	0	1	1	(2)
Total	32	27	59	(100)

sure that the PA student becomes imprinted with a primary care orientation and an appreciation for the potential utilization of the PA in a primary care setting, and (2) a need to increase the visibility of the PA to the Iowa family physician (in practice and training). Demonstrating the capability and potential usefulness of the PA to the family physician is likely to increase the number who choose to employ PA's. In an attempt to resolve these needs, the PA program recently contacted a majority of the primary care physicians in the state to ask if they would be interested in participating in the clinical training program. To date the response has been positive.

It is not unreasonable to expect that as there

is an increase in the number of clinical training sites in non-institutional, low population settings, particularly with primary care physicians, there will be an increase in the subsequent deployment, into these areas, of participating students following graduation.

Twenty-five students were graduated from the U. of I. program in May, 1977 and will be in the employment market. Our Program Office will be pleased to assist any physician in the search for an assistant; for information call 319/353-5711.

REFERENCES

The references noted in this article are available on request either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.



Adventure in Medicine Tour to Southern Africa

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Carcinoma of the Ileum in Regional Ileitis

HERBERT E. GUDE, M.D.

Iowa Falls

This case report describes a patient with long-term ileitis. It supports the belief that development of carcinoma is related to Crohn's disease of the small intestine.

A GENERATION ago medical students learned that Crohn's disease of a chronic state carried with it a number of complications—abscess, fistula formation, perforation, obstruction and hemorrhage. Regional ileitis was thought to be free from malignant degeneration. Ginzburg *et al*¹ reported in 1956 the first case of adenocarcinoma complicating regional ileitis, and Saeed *et al*² reviewed the literature and described the twenty-seventh such case in 1973. A patient with a 22-year history of regional ileitis with subsequent development of adenocarcinoma of the ileum is reported.

CASE REPORT

F.A.C., a 62-year-old, white, married female was admitted to Ellsworth Municipal Hospital, Iowa Falls, Iowa, on January 23, 1974, with nausea, vomiting, abdominal pain and mild abdominal distention.

In 1952 terminal ileitis with obstruction was treated by resection of the distal 18 inches of the ileum and the proximal one-half of the right colon with an end-to-end ileo-ascending colostomy. For 22 years she was relatively asymptomatic other than frequency of stools, generally two to three per day. In 1973, after intermittent bouts of abdominal pain and diarrhea, a roentgenological gastrointestinal series was interpreted as compatible with terminal ileitis. The patient was placed on a regimen of salicylazosulfapyridine and diazepam, and the abdominal symptoms were controlled for a few months.

When the abdominal pain and diarrhea symptoms returned, prednisone was added to the other medications. However, nausea and vomiting with abdominal bloating developed and she was admitted to the hospital. Small bowel obstruction due to ileitis was the admission diagnosis and was confirmed by a flat plate x-ray of the abdomen revealing distended small bowel loops; the physical findings of abdominal distention, right-sided abdominal tenderness and diminished high-pitched bowel sounds. Nasogastric intubation and parenteral fluids were instituted, and the obstructive signs and symptoms were relieved. Within one week the patient was discharged from the hospital tolerating a bland diet well. However, she returned to the hospital seven days later again presenting symptoms and signs of small bowel obstruction.

A laparotomy was performed. The finding was a dense inflammatory obstructive mass of the ileum and proximal colon at the site of the previous resection. A 35 cm bowel segment was resected, and an end-to-end ileo right transverse colostomy was performed. The liver and abdomen were free of any visible or palpable tumors. The patient developed a postoperative subcutaneous wound infection which responded well to antibiotics, and she was discharged on the tenth postoperative day.

Eight months later the patient developed a mass on her upper abdomen. A liver scan described this to be a large metastatic tumor implant with several other smaller hepatic nodules. A course of intravenous 5-Fluorouracil was instituted, but there was no demonstrable response of the growing liver tumor. She became jaundiced and expired on November 23, 1974, nine and one-half months postoperatively.

PATHOLOGIC FINDINGS

Gross Findings. The specimen was stated to represent terminal ileum exhibiting obstructive terminal ileitis. It measured approximately 35 cm in length. Near the midportion of the specimen the wall was extremely narrow. There was flattening of the mucosa folds. At one point, soft

Dr. Gude is in the private practice of medicine in Iowa Falls, Iowa.

gray material contiguous with the central area of abnormality occupied 8 cm of the length of the tissue. Elsewhere in the mucosa there was roughening; but, in general, the mucosal folds persisted. Enlarged lymph nodes were not identified. A portion of omentum was attached to the specimen.

Microscopic Findings. The grossly described area of abnormality was found to be adenocarcinoma. In a few areas there was an attempt at gland formation. Component cells had pleomorphic hyperchromatic nuclei and small amounts of cytoplasm. Many of the nuclei were in mitosis. In most areas the tumor was disposed in confluent irregularly outlined clusters of cells having the cytologic pattern described in the preceding. Many central areas of necrosis were noted. The tumor cell masses extended through the muscularis and into the mesentery. No metastatically involved lymph nodes were identified. Observed elsewhere was focal erosion of the mucosa associated with neutrophilic leukocytes and suffused erythrocytes in the lamina propria of the persistent mucosa.

Diagnosis. Adenocarcinoma, Grade IV, of the ileum with extension through the wall and into the mesentery. Focal acute erosive ileitis.

COMMENT

There seems to be increasing evidence that development of carcinoma is related to long-standing Crohn's disease of the small intestine. In regional ileitis, as in ulcerative colitis, the cure rate is very low once cancer has developed. Prophylactic resection of a segment of small bowel with long-standing history of ileitis is an aggressive approach, but, as with ulcerative colitis, time could degenerate the inflammatory bowel into a likely incurable neoplastic condition. Intestinal obstruction is the major indication for surgery on a patient with regional ileitis of the small intestine. Bypassing the obstructive segment may leave a potentially dangerous situation in which malignancy can develop. Therefore, when signs of intestinal obstruction develop in a patient with long-standing Crohn's disease, prompt surgical resection of the involved segment is indicated.

Appreciation is extended to David Baridon, Jr., M.D., for the pathology report.

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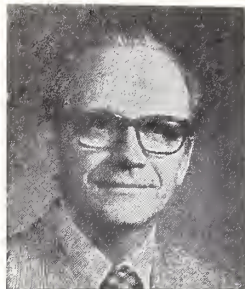
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Editorials

M. E. ALBERTS, M.D., Scientific Editor

FEES FOR PROFESSIONAL SERVICES

The traditional physician-patient relationship has been questioned seriously in recent years. Some studies indicate many people care little about a relationship with any particular physician, seeking medical care rather from any available source. The increasing number of people who report to hospital emergency out-patient departments would seem to attest to this. True, some of these persons would assert this is their only source of medical attention.

In the instance of hospitalized patients much care of a professional nature is provided by persons other than the attending physician. Nurses and ancillary health personnel provide professional care; resident physicians likewise are greatly involved. Herein lies a problem which has been considered by the AMA House of Delegates. In 1966, the House approved a concept wherein a physician could not ethically and honestly receive reimbursement for services, whether medical or surgical, if he did not provide them personally to the patient. These 1966 statements were applicable only to Medicare Part B subscribers.

However, at the 1977 meeting of the AMA House of Delegates, the Ohio delegation presented a resolution to reaffirm the unethical and dishonest nature of a physician making a charge for

services rendered by an intern or resident without personal supervision from the attending physician regardless of payment mechanism. That resolution was superseded by Report H of the Council on Medical Service, which in part reaffirms Resolution 16 of the 1976 AMA session and which refers to "services which are performed under the physician's *personal observation, direction, and supervision*." Furthermore, the fee for this service should not be reduced when rendered with the assistance of interns or residents.

The key words here are the ones in italics. The patient has the right to know his physician, and be assured that any services were rendered by that physician or by a delegated intern or resident under the physician's personal supervision. Many services rendered by hospital employees—interns, residents, clinical nurses and technicians—are on the order of the physician. It would appear that these services do not warrant compensation to the physician especially if the service is rendered when the physician is not personally involved. If our profession does not discipline itself to this end, there may be a resultant survey of hospital chart nursing notes by insurance representatives or governmental agents to determine if the physician has in fact rendered personally, or personally observed or assisted the resident, in the service for which he has submitted a fee.—M.E.A.

THE BUSINESS OF MEDICINE

Legend has it that fly-by-night confidence men find physicians easy prey for speculative investments or non-existent opportunities to become

wealthy. This myth (or truism) stems perhaps from the relative ease with which a young physician achieves a high income shortly after his training years. It is possible he becomes naive

(Please turn to page 327)

EDITORIALS

(Continued from page 326)

about financial responsibility, and perhaps a bit greedy.

The training given medical students includes little opportunity for learning fiscal responsibility. Business principles, office management, and business law seemingly are usually not important enough to be in the curriculum of the aspiring physician. Yet, the practitioner is a businessman. I do not imply that our profession has become a business and is only partly a profession, but still some expertise must be developed to deal with fiscal matters in a professional manner.

The physician must deal with rental or ownership, employment management, office management, governmental regulations, liability concerns, and the legal ramifications of his practice. Why must a person spend years developing professional competence and then possess no skill in the management of that profession?

In decades past to consider the practice of medicine in a business-like manner was considered unethical and unprofessional. Now, with all the governmental and legal aspects of dispensing of health care, it is mandatory for the physician to

"There's nothing wrong with recognizing that a physician must charge and collect for his services. Nor is there anything unprofessional about applying good business management techniques to the running of a medical practice. The doctor who puts his practice on a sound foundation from a management standpoint actually increases the amount of time he can spend with patients."

EXCERPT FROM THE BUSINESS SIDE OF
MEDICAL PRACTICE, PUBLISHED BY THE
AMERICAN MEDICAL ASSOCIATION

have some expertise in office management. The physician must possess fundamental knowledge of accounting, financial analysis and the budgeting of business capital. He must know how to manage his employees, understand the fine points of employer-employee laws, and be conversant about the legal ramifications of his entire office operation. One might argue that such concerns should be the responsibility of the office manager or the accountant. Yet, if the "president of the firm" has no idea how the place operates, he is a poor businessman. After all, he owns the store.

I propose as a requirement for graduation from medical school a student have courses in account-

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ing procedures, management controls, record controls, business law, estate planning, as well as the ethics of business. Any continuing education program can then coordinate professional aspects with business skills. Combined, the two programs can produce a more astute and knowledgeable physician who can provide better service to his patients in a manner that is professionally good and fiscally responsible.

I must emphasize these suggestions are *not* presented to promote methods of making greater financial gains in a more efficient manner at the cost of inferior medical care. Sick people must purchase a service they do not desire. They incur unwanted debts. We need not teach our patients financial responsibility by insisting on cash in advance, or charging interest, or providing inferior service to the "slow pay" types. We provide a service when it is needed by the patient, the money comes later. What I really mean by good business management is the operation of our offices in a professional manner with business integrity. Let us not become "get rich quick" confidence men, leaving our patients as victims of ruthless business practices.—M.E.A.

IOWA HEALTH CARE COSTS RECEIVING ATTENTION

AMONG THE RESOLUTIONS submitted (in May) to the 1977 Iowa Medical Society House of Delegates was one from Story County:

Resolved, That the Iowa Medical Society urge its member physicians to pursue actively and personally efforts to understand those factors which bear on the cost of health care as it is delivered locally and to restrain voluntarily any fee increase to not exceed the cost of living increase for the previous year where this is practical and is not likely to jeopardize the quality of medical care available.

In responding to this resolution, the physician-delegates in the policy-making IMS House called on themselves and their colleagues to be aware of those factors which bear on the cost of health care. The House recited informationally a passage from the American Medical Association Judicial Council Opinions and Reports, i.e., "That a physician try, in matters relating to fees, to the best of his ability to insure justice to the patient and himself and respect for his profession."

This admonition from and to Iowa physicians is a good one, an obvious one and hardly a new one. Seldom does a day pass without reference in the news media to mounting health care costs. Such references are even more abundant in periodicals prepared for health care providers. It hardly needs restatement here that the nation is becoming acutely sensitive to health care economics.

Responses to the dilemma of inflation in health care have varied in magnitude and point of origin (private entity, state government, federal government, etc.). Everyone is asking, is it possible to stabilize or lower costs while maintaining and increasing the quality of care?

This economic concern has spawned a new offensive among Iowa health care leaders. From deliberations in recent months has come the Iowa Cost Effectiveness Committee. Impetus for this inter-organizational unit came in 1976 when Blue Cross and Blue Shield issued a participatory invitation to the Iowa Medical Society, Iowa Foun-

dation for Medical Care and Iowa Hospital Association.

Now in existence is a 16-member committee which has the objective of demonstrating to Iowans that the voluntary sector can provide leadership in preserving the high quality of health care we now enjoy. The members of the Iowa Cost Effectiveness Committee are noted here.

In its early going the Committee adopted a statement which identifies the voluntary sector as having primary responsibility to provide: 1) the finest possible health care coverage at the least possible cost; 2) the highest possible level of service to the community, and 3) a dynamic program of research in the area of health care prepayment and delivery.

Areas for study and possible action are numerous. These include the actual and projected number of needed acute hospital beds, the use of alternate methods of hospital and physician services, the design of benefit programs, the responsibility of the consumer, etc.

At a time when the federal administration is advocating a cap on annual hospital cost increases, and as various governmental entities deliberate mandatory rate setting for health care, the key question arises: Can the private sector respond forcefully and effectively to counter the pressure and power of government?

This is the challenge. And one worthy of an all-out try!

IOWA COST EFFECTIVENESS COMMITTEE

Carl Aschoff, M.D., Cedar Rapids; James Bishop, M.D., Davenport; John Colloton, director, University of Iowa Hospitals and Clinics, Iowa City; Donald Cordes, executive vice president, Iowa Methodist Medical Center, Des Moines; Donald Dunn, president, Iowa Hospital Association, Des Moines; Arthur Downing, M.D., Des Moines; Fred Ferree, director, Iowa Foundation for Medical Care, West Des Moines; Eldon Huston, executive vice president, Iowa Medical Society, West Des Moines; Charles Ingersoll, executive director, Broadlawns Polk County Hospital, Des Moines; Glenn Johnson, Cedar Rapids; Dean Klecknor, president, Iowa Farm Bureau Federation, West Des Moines; Charles Linden, administrator, Boone County Hospital, Boone; Enfred Linder, M.D., Ogden; Kenneth Lister, M.D., Ottumwa; Charles Patterson, Blue Cross Hospital Advisory Committee, Sioux City; John Rhodes, Sr., M.D., Pocahontas.

IN THE PUBLIC INTEREST



Educationally Speaking

by R. M. CAPLAN, M.D.

1876

Today I meandered with pleasure through a reconstituted version of the Centennial Exposition that took place in Philadelphia in 1876. This new version resides at the Smithsonian Institute in Washington. One corner of the totally amazing collection was devoted to the latest items for medicine and dentistry of the day. How strange the practice of medicine must have been a mere 100 years ago!

Just a few of the displayed items:

- Medicine-vial corks of all sizes (now displaced totally by safety-top plastic)
- Rows of containers for herbs and chemicals beside balances on which to weigh them (all now delegated to pharmacists, and in turn to pharmaceutical manufacturers)
- A copy of a biography, "Hahnemann—The Founder of Scientific Therapeutics" (bizarre to find "scientific" as the adjective describing the basis of homeopathy)
- Lovely new dental chair covered by a rich red velvet (no easy-to-wipe vinyl—maybe the deep red cover concealed the stains of bloody spit)
- An up-to-the-minute dental drill (operated by a foot-treadle); what physician of today would have the faintest notion of the technique, equipment or indications for pulling a tooth?

I shudder to think of the intense and bitter political struggles that must have occurred in establishing pharmacy as an independent discipline, or eliminating homeopathic education and practice. Even in the 1950's the catalogue at the University of Iowa was obliged by state law to list

some courses in homeopathy, although the requirement of at least 25 students precluded any prankster from forcing the University to actually give the courses.

A few items on display—the stethoscope, the amputation saw—were recognizable, yet so different from today's models. The item I saw most like today's counterpart was the low-outlet obstetrical forceps. Even pills were all spherical (a shape seldom used today).

Students in those days had to learn an incredibly great and useless pharmacopoeia. And notions of pathogenesis that are laughable! Today's students learn about endoplasmic reticulum and how to operate a computer terminal. We think we have come so far—but the humbling aspect of such a museum visit is to think how ludicrous our ways will seem in 2076. Our progress reminds us that continuing education has always been with us, and predicts that it always will.

IMMUNIZATION RULES . . . Operative procedures for Iowa's new immunization law have been under development this summer. Two meetings of a State Department of Health Advisory Committee have occurred. Under the new law, except for religious or medical reasons, children enrolling in elementary or secondary school or a licensed child care center must be immunized against diphtheria, pertussis, tetanus, poliomyelitis, rubeola and rubella. The possibility of an injunction exists fostered by those who believe the individual should be exempted based on his own conscience.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

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Tedral: Adults—One or two tablets every 4 hours. **Children**—(Over 60 lb) one-half the adult dose.

Tedral SA: Adults—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. **Children**—Not established for children under 12.

Tedral Elixir: Note: One teaspoonful is equivalent to one-quarter Tedral tablet. **Children**—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. **Adults**—One to two tablespoonfuls every four hours.

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Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

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REQUEST PHYSICIAN HELP IN HAND-ABNORMALITY STUDY

The U. S. Department of Health, Education and Welfare is supporting a study by the Division of Hand Surgery at the University of Iowa College of Medicine. The study is directed at the identification and treatment of hand deformities. HEW support for this research dates back to the 1960's and was granted because the population in Iowa is relatively static and because complete records have been maintained since the U. of I. Orthopedic Department was founded nearly 60 years ago.

Results of this study have been so satisfactory that further research has now been funded. The project staff hopes Iowa physicians will continue their cooperation by identifying additional patients.

Over 1,400 patients with congenital deformities of their hands have now been identified. An analysis of the major diagnoses has shown syndactyly is by far the most common deformity, and polydactyly is second. Of more interest, however, are the rare conditions which have only occasionally or never before been reported in the literature. Some people have contended, for example, that polydactyly of the index finger is non-existent, but the U. of I. research team has found seven patients with a total of 11 duplicated index fingers. Other anomalies described in 16 scientific papers already prepared or presented on the results of this survey include radial club hand, ulnar club hand, polydactyly of the thumb, polydactyly of the central digits, acrosyndactyly, symphalangism, symbrachydactylia, camptodactyly, delta phalanx, Poland's syndrome, triphalangial thumb, and Apert's syndrome.

The main objective of the current study is to establish the total count of child and adult patients and the types of deformity. Additionally, there is a desire to see if family histories show recurrences of these conditions. Treatment suggestions can be made and care offered through existing state programs and agencies if requested, but there is no intention of interfering with the treatment of patients already under physicians' care.

A special office is maintained in Children's Hospital for the project, and all inquiries should be addressed to: Congenital Hand Study Project, Children's Hospital, Iowa City, Iowa 52242. The telephone number is 319/356-2363.

State Department of Health

INFLUENZA VACCINE

The following discussion contains the 1977-78 recommendations of the Public Health Service Committee on Immunization Practices and is taken from the Morbidity and Mortality Weekly Report of the Center for Disease Control.

Influenza occurs in the United States every year, but with great variation in incidence and geographic distribution. It periodically becomes epidemic when the antigens of prevalent influenza viruses have changed enough for a significant proportion of the population to become susceptible. More epidemics are caused by influenza A viruses than by influenza B viruses, and influenza A epidemics are notable for causing mortality in excess of what is normally expected. Furthermore, only influenza A viruses undergo major antigen changes that result in pandemics (worldwide epidemics).

An example of the sudden appearances of antigenically distinctive influenza A viruses occurred in February 1976, when A/New Jersey/76 (swine) influenza virus was identified as the cause of a focal epidemic at Fort Dix, New Jersey. Recognition of the potential of this new virus for supplanting prevalent strains of influenza A, the threat of subsequent pandemic spread, and the Federal program to provide specific swine influenza vaccines in 1976 are well known. The fact that A/New Jersey/76 virus did not spread beyond Fort Dix makes it unlikely that this virus constitutes a risk in 1977-78. Nevertheless, because swine influenza viruses continue to exist in swine in the United States and to cause occasional human cases, primarily in those with agricultural exposures, the swine influenza vaccines remaining from 1976 have been stockpiled in the event of future need.

Thousands of persons have died of influenza in epidemics in the United States in the past 20 years. In the 1957-58 influenza season, when a

new influenza A virus (Asian strain) appeared, nearly 70,000 deaths were attributed to it in this country alone. In 1968-69, when the Hong Kong variant caused widespread epidemics in the United States, there were an estimated 33,000 excess deaths. In the intervening years, whenever influenza A epidemics have involved most of the country, 10,000 to 20,000 excess deaths resulted.

Efforts to prevent or control influenza in the United States usually have been aimed at protecting those at the greatest risk of becoming seriously ill or dying. Repeated observations during influenza epidemics have indicated that deaths occur primarily among chronically ill adults and children and in older persons, especially those over age 65. These "high-risk" persons should be vaccinated annually regardless of the amount of influenza in their geographic areas.

In interpandemic periods, vaccinating the entire population has not been considered to be a reasonable public health objective for several reasons: the limited duration of protection from influenza vaccines, the relatively low attack rates of influenza in community outbreaks, and the usual lack of serious complications of disease in healthy people.

INFLUENZA VIRUS VACCINE FOR 1977-78

The Bureau of Biologics, Food and Drug Administration, reviews influenza vaccine formulation regularly and recommends reformulation with contemporary antigens when indicated. Bivalent influenza vaccine for 1977-78 will contain inactivated influenza A and B viruses representative of currently prevalent strains. Each adult dose of vaccine will contain 400 chick cell agglutinating (CCA) units of antigen or its equivalent in the following proportion: 200 CCA units of influenza A virus comparable to the prototype A/Victoria/3/75 (H3N2) and 200 CCA units of B/Hong Kong/5/72 influenza virus.

TABLE 1. INFLUENZA VACCINE DOSAGE BY AGE, 1977-78

Age	Product Type	Dose Volume (ml)	Total CCA Units*	Number of Doses
18 years and older	Whole-virus or Split-virus	0.5	400	1
6-17 years	Split-virus	0.5	400	1
3-5 years	Split-virus	0.25	200	2**
6-35 months	Split-virus	0.15	120	2**

* Representing equal amounts of A/Victoria/75 and B/Hong Kong/72.

** 4 weeks or more between doses; both doses essential for good protection.

The 1977-78 vaccine will be available in "split-virus" and "whole-virus" preparations. Split-virus vaccines, which contain antigens produced by chemically disrupting the influenza virus, have been associated with somewhat fewer side effects than whole-virus vaccines, particularly in children. However, the split-virus vaccines appear to be somewhat less effective in eliciting antibodies when given as a single dose to persons who have not been "primed" by exposure to related viruses in nature or through vaccination.

The characteristic side effects and immunogenicity of split-virus and whole-virus influenza vaccines are important in understanding dosage recommendations for various age groups. Adults and older children, most of whom have had experience with influenza antigens related to A/Victoria/3/75 or B/Hong Kong/5/72 either by infection or through vaccination, can be expected to have a good antibody response to a single dose of the 1977-78 bivalent influenza vaccine. Children less than 6 years of age, some of whom have not encountered the currently prevalent viruses, will need 2 doses of vaccine given 4 or more weeks apart in order to achieve satisfactory antibody responses. These children will not be adequately protected unless the second dose is given. Furthermore, because children and adolescents tend to experience somewhat more side effects from influenza vaccine than adults, *only* split-virus vaccines should be given to persons less than 18 years of age.

VACCINE USAGE

General Recommendations

Annual vaccination is strongly recommended for adults and children of all ages who have such chronic conditions as: 1) heart disease of any etiology, particularly with mitral stenosis or cardiac insufficiency, 2) chronic bronchopulmonary diseases, such as chronic bronchitis, bronchiec-

tasis, tuberculosis, emphysema, and cystic fibrosis, 3) chronic renal disease, and 4) diabetes mellitus and other chronic metabolic disorders.

Vaccination is also recommended for older persons, particularly those over age 65 years, because excess mortality in influenza outbreaks occurs in this age group.

Vaccination may also be considered for persons who provide essential community services and may be at increased risk of exposure. Vaccination of such persons and of patients not specified in the high-risk groups should be made on an individual basis giving consideration to the inherent benefits, risks, and costs.

The accompanying table summarizes vaccine and dosage recommendations by age group for 1977-78. These recommendations are derived from observations made during the field trials of influenza vaccines conducted in 1976. Because information from the immunization of infants and young children is limited, the dosages recommended for them are conservative.

SIDE EFFECTS AND ADVERSE REACTIONS

Side effects of influenza vaccine occur infrequently. Three types of responses to influenza vaccines have been described:

1. Fever, malaise, myalgia, and other systemic symptoms of toxicity starting 6-12 hours after vaccination and persisting 1-2 days. These responses to influenza vaccine are usually attributed to characteristics of the influenza virus itself (even though it is inactivated) and constitute most of the side effects of influenza vaccination. Such effects occur most frequently in children and others who have had no experience with influenza viruses comparable to the vaccine antigen(s).

2. Immediate—presumably allergic—responses, such as flare and wheal or various respiratory ex-

pressions of hypersensitivity. These reactions are exceedingly uncommon but can occur after influenza vaccination. They probably derive from exquisite sensitivity to some vaccine component, most likely residual egg protein. Although current influenza vaccines contain only a minute quantity of egg protein, they can, on rare occasions, provoke hypersensitivity reactions. Individuals with known or suspected hypersensitivity to eggs should be given influenza vaccine only under the care and close observation of a physician.

3. Guillain-Barré syndrome, usually a self-limited paralysis, is observed within 8 weeks after influenza vaccination in approximately 10 of every million persons vaccinated. It also occurs, but less frequently, in unvaccinated persons. Prior to the intensive surveillance of influenza vaccine that occurred during the swine influenza vaccination program in 1976, serious adverse reactions, such as this syndrome, to influenza vaccines had been virtually unrecognized. While the risk is not high, persons who receive influenza vaccine should be aware of it and should recog-

nize that 5-10% of persons with the Guillain-Barré syndrome have residual weakness to some degree and approximately 5% of them die.

PREGNANCY

Elevated rates of maternal and fetal mortality and of congenital anomalies and other fetal effects resulting from influenza infection during pregnancy have been widely discussed. Numerous reports from the 1918-19 influenza pandemic and a few small but better controlled studies in 1957-58, when the Asian influenza pandemic occurred, suggested that influenza can cause increased maternal and fetal deaths. However, a number of more recent, prospective studies have failed to corroborate those findings. Thus, although there are no persuasive data to document that pregnancy is a risk-factor with influenza, the effect of influenza in pregnancy cannot be forecast with assurance. Physicians generally avoid prescribing unnecessary drugs and biologics for pregnant women, especially in the first trimester; however, there are no data that specifically contraindicate influenza vaccination in pregnancy.

Morbidity Report for June, 1977

Disease	June 1977	1977 to Date	1976 to Date	Most June Cases Reported From These Counties
Amebiasis	31	67	32	Boone
Chickenpox	255	7353	8921	Black Hawk, Linn
Conjunctivitis	104	1714	1470	Black Hawk, Clinton
Encephalitis unspecified	1	2	2	Johnson
Erythema infectiosum	2	49	154	Black Hawk, Marshall
Gastrointestinal viral infection	345	16190	16233	Linn, Sioux
Giardiasis	15	45	16	Boone
Hepatitis				
A infectious	9	55	68	Linn, Sioux
B serum	12	65	50	Linn, Polk
unspecified	8	18	9	Scattered
Impetigo	32	396	482	Jones, Lee
Infectious Mononucleosis	41	686	662	Dubuque, Johnson
Influenza-like illness	344	40,380	42,202	Johnson, Linn
Meningitis, unspecified	2	6	3	Johnson, Linn
Mumps	26	1253	1184	Black Hawk
Pediculosis	23	226	269	Black Hawk, Clinton
Pinworms	7	29	21	Polk

Disease	June 1977	1977 to Date	1976 to Date	Most June Cases Reported From These Counties
Pneumonia	59	584	674	Scott
Rabies in Animals	9	62	71	Scattered
Rheumatic Fever	1	26	—	Carroll
Ringworm				
body	9	183	165	Black Hawk
scalp	1	6	18	Marion
Rocky Mountain Spotted Fever	3	4	—	Scattered
Rubella	16	173	90	Johnson
Rubeola	473	4328	47	Polk, Scott
Salmonellosis	20	95	56	Linn, Polk
Scabies	44	583	425	Black Hawk
Shigellosis	5	22	37	Linn
Streptococcal infections	511	8352	10,554	Johnson, Polk
Tuberculosis				
total ill	11	85	51	Scattered
bacteria positive	11	43	45	Scattered
Venereal diseases				
Gonorrhea	645	2906	3237	Linn, Polk
Syphilis	17	175	163	Polk
<i>Laboratory Virus Diagnosis Without Specified Clinical Syndrome</i>				
Adenovirus—1,				Coxsackie infection—1,
Cytomegalovirus—3,				Herpes simplex—12.

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

About IOWA Physicians

The new St. Luke's Hospital Education Facility in Cedar Rapids has been named in honor of **Dr. Charles Schwartz**, family practitioner and member of medical staff for 22 years. Dr. Schwartz received the M.D. degree at U. of I. College of Medicine and began his family practice in Cedar Rapids in 1955. For 20 years he has directed internship programs at the hospital and was instrumental in the establishment of the Family Practice Residency program at St. Luke's. **Dr. Vera French**, Davenport, executive director of the Community Mental Health Center of Scott County, was named a fellow in the American Psychiatric Association.

Dr. Robert J. Barry has been named chairman of the Linn County unit of the American Cancer Society and **Dr. R. E. Weland** and **Dr. Julianne Thomas**, board members. All are Cedar Rapids physicians. . . . **Dr. Dennis Crabb** has joined his father, **Dr. D. N. Crabb**, and **Dr. R. L. Bendixen** in medical practice in Denison. A 1972 graduate of the U. of I. College of Medicine, Dr. Crabb recently completed his surgical residency at Iowa Methodist Hospital in Des Moines. . . . **Dr. Arnold Delbridge**, former Dubuque orthopedic surgeon, has relocated in Cedar Falls. Dr. Delbridge received the M.D. degree at Northwestern University Medical School in Chicago and completed his internship and residency at Cook County Hospital, also in Chicago. . . . **Dr. Joseph Troitzig** was honored recently at an open house commemorating his 25th year in Akron. A graduate of U. of I. College of Medicine, Dr. Troitzig began his medical practice in Akron in 1952. . . . **Dr. Laurence K. Rasmussen** began the family practice of medicine in Chariton in July. Dr. Rasmussen received the M.D. degree at Creighton University College of Medicine in Omaha, Nebraska and served his family practice residency


at Broadlawns Hospital in Des Moines. . . . **Dr. Victor N. Suarez** recently opened a medical practice in Anthon. Dr. Suarez received his medical education at the University of Guayaquil in Ecuador; interned at St. Joseph Hospital in New York City; and served two and a half years in a surgery residency at Mt. Vernon Hospital in Mt. Vernon, New York.

Drs. Somchit and Pairote Poommipanit have assumed the medical practice of **Dr. Saman Choontanom** in Rock Valley. Dr. Choontanom is relocating in California. . . . **Dr. Christina Rabo** began the practice of obstetrics and gynecology in Fort Madison on August 1. Dr. Rabo received the M.D. degree at the University of Santo Tomas, Manila, the Philippines; served her internship in Manchester, Connecticut; and completed her residency in Brooklyn, New York. Since 1970, Dr. Rabo has been in practice as a hospital-based physician in obstetrics and gynecology in New Brunswick, New Jersey. . . . **Dr. Gerald J. Wieneke** joined Medical Associates in Emmetsburg on August 1. A native of Cascade, Dr. Wieneke received the M.D. degree and completed his family practice residency at Creighton University School of Medicine in Omaha, Nebraska. . . . **Dr. Jaime Polit**, Fort Madison, terminated his practice of internal medicine at Valley Clinic June 30. Dr. Polit is returning to Ecuador. **Dr. Artemio C. Santiago**, who has been serving a residency in internal medicine at the VA Hospital in Allen Park, Michigan, is planning to assume Dr. Polit's practice. Dr. Santiago attended medical school at the University of Santo Tomas in Manila, the Philippines. . . . **Dr. Kenneth Hunziker** began a family practice at Medical Associates in Spencer in July. A native of Independence, Dr. Hunziker received the M.D. degree at U. of I. College of Medicine and completed his family practice residency in Cedar Rapids.

Dr. Paul V. Hart has joined **Dr. D. E. Mitchell** in family practice in Mount Ayr. A former Des Moines physician and surgeon, Dr. Hart received the M.D. degree at Creighton Medical School in Omaha, Nebraska, and took his postgraduate training at Stanford University, San Francisco, California, and Iowa City. . . . **Dr. John Mayer**, a Washington native, has joined the West Union Medical Clinic. Dr. Mayer received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at St. Paul's Ramsey Hospital in St. Paul, Minnesota. . . . **Dr. Stanley Levine**, Ottumwa, has been elected to fellowship in the American Academy of Pediatrics. . . . **Dr. David Thomas** is new associate of **Dr. Charles D. Bendixen** in Marshalltown. Dr. Thomas received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Rockford, Illinois. . . . **Dr. Howard Beatty**, longtime Creston physician, retired August 1. Dr. Beatty received the M.D. degree at U. of I. College of Medicine and interned at Salt Lake County General Hospital in Salt Lake City, Utah. He began his medical practice in Creston with his father, the late Dr. A. S. Beatty, in 1932. Dr. Beatty is one of the charter doctors of the Creston Medical Clinic, which opened August 3, 1953. He is a past chief of staff at Greater Community Hospital in Creston; past president of the Creston Kiwanis Club; and member of the American Association of Railway Surgeons.

Dr. Maurice Huffman joined Park Physicians in Humboldt in July. A Sac City native, Dr. Huffman received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Davenport. . . . **Dr. Henry Hanson** has been elected chief of staff of Waverly Municipal Hospital; **Dr. David MacMillan**, vice chief of staff; and **Dr. Daniel Eggers**, secretary-treasurer. All are Waverly physicians. . . . **Dr. Ludwig Gittler** terminated his medical practice in Fairfield June 30. Dr. Gittler received the M.D. degree at the University of Munich in Germany, and interned in Nuremburg. He came to the United States in 1924 and established his medical practice in Fairfield in 1930. Dr. Gittler is a life member of the Iowa Medical Society. . . . **Dr. John A. Wolpert** and **Dr. William R. Blankenship** have recently come to Sioux City. Dr. Wolpert, a urologist, joined **Drs. Dwayne Howard, Robert Boldus** and **Peter Poor**. He received his


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M.D. degree at Creighton University in Omaha, Nebraska; interned and completed his residency in urology at St. Paul Ramsey Hospital in St. Paul, Minnesota. Dr. Blankenship is an emergency room physician at St. Luke's Medical Center and Marion Health Center Hospitals. He received the M.D. degree at Cornell University Medical College in New York City; interned and received his residency training in internal medicine and pediatrics at Strong Memorial Hospital in Rochester, New York. . . . **Dr. Millard Petersen**, Atlantic physician for 41 years, retired July 1. Dr. Petersen received the M.D. degree at University of Nebraska School of Medicine in Omaha. He located in Atlantic in 1936. Dr. Petersen was honored recently at an open house hosted by employees of the Atlantic Medical Center.

Dr. F. L. Scharf has joined **Drs. D. W. Powers**, and **L. C. Pang**, in the practice of pathology in Ames. A Canada native, Dr. Scharf received his medical training at McGill University and Montreal General Hospital in Montreal, Canada; and Deer Lodge Hospital in Winnipeg. He continued his training in the United States at Baptist Me-

morial Hospital in Memphis, Tennessee, and University of Oklahoma Medical Center at Norman, Oklahoma. Dr. Scharf is certified by American Board of Pathology in clinical and anatomical pathology and is also board certified in blood banking. . . . **Dr. Vincent Sullivan** joined the Clinic in Leon in July. Dr. Sullivan received the M.D. degree at U. of I. College of Medicine where he also completed his internship and surgical residency. . . . **Dr. John Christiansen**, Durant, was honored recently at an open house for his 40 years of medical service to the community. A plaque was presented to Dr. Christiansen commemorating the event. Dr. Christiansen received the M.D. degree at U. of I. College of Medicine and interned at St. Luke's Hospital in Duluth, Minnesota.

Dr. Bill Follows, orthopedic surgeon, joined the staff at Spencer Municipal Hospital in July. Dr. Follows received the M.D. degree at Columbia College of Physicians and Surgeons in New York. After his internship at Dartmouth in New Hampshire, and a one-year general surgery residency in Vancouver British Columbia, Dr. Follows completed his orthopedic residency at the University of Virginia in Charlottesville. Dr. Follows is a fellow of the American Academy of Orthopedic Surgeons and a diplomate of the American Board of Orthopedic Surgery. . . . **Dr. C. Joseph Plank** began the private practice of dermatology at the Medical Arts Center in Mason City on August 1. Dr. Plank received the M.D. degree at U. of I. College of Medicine; interned at the University of Southern California Medical Center and completed his dermatology residency at the University of California, Irvine.

Dr. E. E. Lister recently completed 25 years of practice in Dallas Center. Dr. Lister received the M.D. degree at U. of I. College of Medicine; interned at Iowa Lutheran Hospital in Des Moines; and in 1952 joined **Dr. William A. Castles** in Dallas Center. . . . **Dr. Vasu Arora**, an internist, opened a practice in Epworth in July. Dr. Arora received his medical training in India at Punjab University. He has been in the United States since 1964 and is currently practicing in Memonimnee, Wisconsin. . . . **Dr. Richard Fowler**, Iowa City, has accepted a position at the University of California Medical School in San Diego, California. For the last three years, Dr. Fowler has been assistant professor of psychiatry at U. of I.

College of Medicine and staff physician at VA Hospital. . . . **Dr. Carl O. Lester**, Marshalltown, was guest speaker at recent meeting of Cedar Falls Rotary Club. Dr. Lester discussed developments in orthopedic surgery. . . . **Dr. Clark Hampe**, internist, has joined the Bluff Medical Center in Clinton. Dr. Hampe received the M.D. degree at U. of I. College of Medicine. He interned and completed his internal medicine residency at White Memorial Hospital in Temple, Texas. . . . **Dr. Ronald M. Larsen** has joined **Dr. Robert Powell** in the practice of psychiatry in Mason City. An Ames native, Dr. Larsen received the M.D. degree at U. of I. College of Medicine and spent three years as a psychiatric resident at Washington University in St. Louis, Missouri. Prior to locating in Mason City, Dr. Larsen was with the Kersten Clinic in Fort Dodge.

DEATHS

Dr. George H. Ashline, 67, Keokuk, died June 7 at his home. Dr. Ashline received the M.D. degree at the University of Illinois School of Medicine; interned at Augustana Hospital in Chicago; and completed his residency in surgery at Shriners' Crippled Children's Hospital, also in Chicago. He was a past president of the Iowa Clinical Surgical Society and member of the American Society of Abdominal Surgeons.

Dr. Earl N. Bossingham, 70, Clarinda, died June 23 at the Clarinda Municipal Hospital. Dr. Bossingham received the M.D. degree at the University of Minnesota and began his medical practice in Clarinda in 1936. He was a World War II veteran and Charter Fellow of the American Academy of Family Practice.

Dr. Wesley M. Page, 55, former Montezuma physician, died July 2 at Rockford, Illinois. Dr. Page received the M.D. degree at U. of I. College of Medicine. Following 12 years in medical practice at Montezuma, Dr. Page returned to U. of I. College of Medicine and completed his residency in anesthesiology. Following his residency, he located in Rockford, Illinois.

Medical Assistants



by **BETTY EHLERT, CMA-A**

AAMA MEMBERSHIP

To be effective as a member of the health care team, a proficient medical assistant must keep up with the changing times. Her knowledge of new procedures and medical advances should parallel that of her physician employer.

Members of the American Association of Medical Assistants participate in various organized educational activities, planned meetings and symposia, study groups, lectures, and continuing education programs. They are encouraged to attain status as Certified Medical Assistants. Through seminars and workshops they earn continuing

educational units (CEUs) whenever possible.

Annual state and national meetings, in addition to regular chapter meetings, offer a further opportunity to receive information on the latest developments in health care.

For example, the 1977 National AAMA meeting will be in San Francisco from October 15 to 22 at the St. Francis Hotel. (Further details will appear in the September issue of *IMS JOURNAL*.)

On the state level, the Black Hawk County Chapter has scheduled a seminar, "Reach Out and Touch—Let's Make Certification Your Specialty," on October 8, with Charlotte Lewis, CMA-C, Waterloo, as district education chairman.



HONOR IMS JOURNAL—The *IMS Journal* was honored recently for its support of the Iowa Chapter, AAMA. Shown above are Margaret Porter, left, and Jeanne Green presenting a certificate to Don Neumann.

IMS JOURNAL CITED

Donald Neumann, managing editor of the *IOWA MEDICAL SOCIETY JOURNAL*, was presented a Certificate of Appreciation recently for his assistance and support of the American Association of Medical Assistants. The certificate was presented at the 1977 session of the *IMS House of Delegates* by Jeanne Green, CMA-A, national president-elect, Davenport, and Margaret Porter, CMA-AC, state president, Cedar Rapids.

MIDWEST REGIONAL CONFERENCE

The Scott County Chapter hosted a Midwest Regional Conference June 11 and 12 at Jumer's Castle Lodge, Bettendorf, with medical assistant leaders attending from Indiana, Wisconsin, Michigan, Minnesota, Illinois, Kentucky, Ohio and Iowa. Margaret Porter, CMA-AC, Cedar Rapids, president of Iowa State Society AAMA, presided at the meeting. Jean Gold and Nancy Winter co-chaired the conference, assisted by Marcine Sanders, CMA-A, Roma Brown and Margaret Griffith, all of Davenport.

Paul A. Hauck, Ph.D., clinical psychologist from Rock Island, Ill., presented an interesting lecture entitled "Do You Want to Lead? Know Yourself."

An "Open Forum Discussion" was led by Luella Mitchel, national trustee, Chicago, with state presidents presenting association activities, ideas and questions for group discussion. Laura Lockhart, CMA-A, immediate past national president, Akron, assisted by Mabel Ann Veech, national trustee, Louisville, held a mock House of Delegates with group participation.

It was a "learning experience," with a good exchange of ideas, thus broadening the scope and effectiveness of medical assistant leaders.

LIST YOUR WANTS

CLASSIFIED ADVERTISING RATE—\$1 per line, \$10 minimum per insertion. NO CHARGE TO MEMBERS OF IOWA MEDICAL SOCIETY. Copy deadline—10th of the month preceding publication.

OB-GYN, PEDIATRIC SPECIALISTS needed by 16-man multi-specialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., LaCrosse Clinic, 212 South 11th Street, LaCrosse, Wisconsin 54601.

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OFFICE SPACE AVAILABLE—immediate occupancy. Des Moines Medical Center, 1,430 square feet of space. Mercy-Lutheran-Methodist close. Lease, possible sell. 1047 5th Avenue, Des Moines, Iowa. Phone 244-9141.

FOR SALE—lease or rental as you desire. Complete general practice set up available immediately due to doctor's illness. Ten other doctors as well as psychiatric consultation in local area. CONTACT Earl N. Bossingham, M.D., 117 West Main Street, Clarinda, Iowa 51632. Phone 712/542-3916.

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FAMILY PRACTITIONER WANTED—to join an eight-man group with a four-man family practice department. Clinic facilities good. Complete with X-ray, physical therapy and laboratory. First year employee, second-year partnership. Excellent benefits and income available. For further information contact G. W. Glenn, Waterloo Surgical and Medical Group, 1125 West 4th Street, Waterloo, Iowa 50702. 319/291-5100.

ORTHOPEDIC SURGEON, OPHTHALMOLOGIST, OBSTETRICIAN-GYNECOLOGIST, INTERNIST-CARDIOLOGIST, OTOLARYNGOLOGIST WANTED—to join established 18-man multi-specialty group in north central Iowa. Immediate full financial partnership and outstanding benefits. New clinic building and hospital. Progressive community with excellent schools and recreational facilities. Address your inquiry to No. 1527, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

OPHTHALMOLOGIST—to practice in suburban Omaha, utilizing new 615-bed Medical Center Complex. Scarcity of ophthalmologists in greater Omaha (none in medical center area of 110,000) assures attractive opportunity. Office space available in new physicians' office building adjoining hospital. Fine schools, recreation, stable economy, major universities. Contact Hans M. Link, President and Chief Executive Officer, Immanuel Medical Center, 6901 North 72nd Street, Omaha, Nebraska 68122 or call collect 402/572-2270.

EMERGENCY MEDICINE—Physician for major suburban hospital. One of five full-time M.D.'s. New department. Hospital based specialists in neonatology, pulmonary disease, pathology, cardiology, radiology and anesthesia. Full partnership after two years. Tax-sheltered annuity available and retirement provided. Existing four M.D.'s average age is 34. Contact Joseph R. McCaslin, M.D., Director of Emergency Medicine, Archbishop Bergan Mercy Hospital, Omaha, Nebraska 68124. 402/398-6031.

FOR SALE: Emergency Room Table—Shampaine Co., Model N-2, tilts etc. for proctos, hand operated, \$300.00. Small Sterilizer—Dak Model 651, inside tray 5x10", \$10.00. Pressure sterilizer, Dak, heavy aluminum, requires gas burner, \$25.00. Picker X-ray, 100MA, rotating anode, tilt table, motor driven with dark room equipment, \$500.00. EKG, Bircher Model 335, 12 leads, looks like new, \$300.00. Leitz Photometer, \$50.00. International Micro-capillary Centrifuge, \$20.00. Write or call H. L. Vander Stoep, M.D., 19 Second Ave. N.W., Le Mars, Iowa 51031. 712/546-5111 or 712/546-4621.

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President's Page

The Fall Conference for County Medical Society Presidents is an IMS-sponsored event that's drawn extremely favorable comment the past several years. The 1977 Conference will be on Wednesday, October 19, at Society Headquarters in West Des Moines.

The Conference has two basic purposes: First, to bring to medical leaders at the county level a status report on various current and pressing health care issues. And secondly, to function as a source of grass-roots feedback for the Society's officers.

County society presidents (or their designated representatives) are the primary invitees. But others may attend too, from various key IMS committees, from the Auxiliary, etc. Preceding the Conference, a new member seminar will be on Tuesday (October 18) afternoon, with those who attend invited to stay over for the Conference. We are anxious to meet new members, have them meet us, and see our lovely headquarters.

Subjects this year? There are several. Implementation of the new Iowa law wherein state licensing boards must require continuing education of their license-holders—how is this going to work? The question of quality care versus dollar cost—involved here is the proposed federal cap on hospital charges, and other matters relating to health care costs. It'll be provocative.

We've had physician representatives from upwards of 70 counties in past years. We hope to achieve or surpass this level in 1977. We think it's important for all county societies to be represented—and to take the highlights back home. We'll be looking for you!



L W Swanson M.D.

L. W. Swanson, M.D., President

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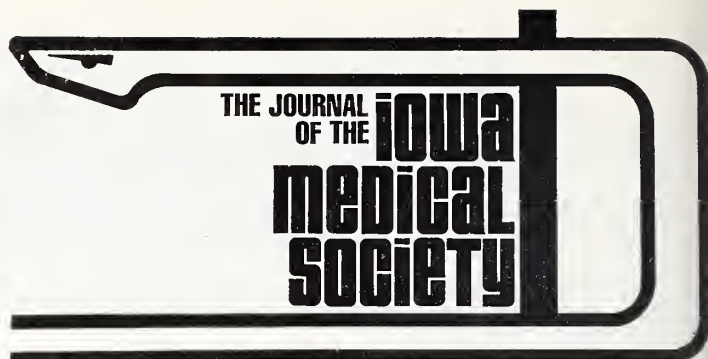
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VOL. 67, No. 9

SEPTEMBER 1977

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IOWA Medical Miscellany

FALL CONFERENCE . . . Fall calendar of IMS events will be headlined by a Conference for County Society Presidents (or their designated representatives). This popular event will be Wednesday, October 19, at IMS Headquarters. More specific info will be distributed to county medical societies. Inquiries may be directed to IMS Headquarters.

NEW MEMBERS . . . A seminar for new IMS members will precede the Fall Conference by one day, occurring the late afternoon and evening of Tuesday, October 18. This session is for physicians affiliating with the Society in the previous 12 months. Highlights of the IMS program are presented.

CONFERRING . . . Representatives of the Board of Medical Examiners, IMS and Iowa Society of Osteopathic Physicians and Surgeons are conferring on the implementation of the new law which requires licensing boards to instigate programs of continuing education for their license holders.

NEW ACCOUNT SUPERVISOR . . . Darrell Chapman has been named account supervisor for the IMS/Aetna Liability Insurance Program. He succeeds Roger Detrich, who has been promoted to the home office to handle responsibilities over all nine of Aetna's state programs. Participation in the IMS/Aetna is approaching the 500 mark in number of physicians at the end of six months.

AUXILIARY WORKSHOP . . . The Iowa Medical Society Auxiliary will conduct a public affairs workshop at IMS Headquarters on Thursday, October 27, beginning at 10 a.m. Health planning activities will be covered with Health Commissioner Norman Pawlewski, Health Systems Agency Director John Ross and HSA Board member L. O. Ely, M.D., participating.

FALL LECTURES . . . A series of bi-weekly evening lectures for physicians and pharmacists will occur in September and October in Waterloo, Mason City, Newton, Davenport and Fairfield. Sponsored by the U. of I. College of Medicine and Pharmacy, the three-part series will deal with computerization in pharmacy, therapeutics of urinary tract infections and a review of self-medication products. CEU credit will be allowed. Further info is available from Professor Wendle Kerr, U. of I. College of Pharmacy, Iowa City, Iowa 52242.

WC AUDIT ACTIVITY . . . Underway in recent weeks has been the required audit of those physicians' offices participating in the Worker's Compensation program available through the IMS. Once this is accomplished the Dodson Insurance Group can calculate the earned savings. This savings is then distributed by the Society to those involved in the program.

HOME NURSING . . . Dispersal has begun of a \$1.6 million state appropriation to supplement existing funding of Iowa public health nursing and visiting nurse services, plus homemaker/home health aide services. A formula was established for the allocation of these funds to the local level with county boards of health having to apply. Physician referral of patients to these services has been encouraged whenever appropriate.

UNIQUE SEMINAR . . . A medical seminar for physician-geese hunters is available October 20 and 21 in Pierre, South Dakota. The event, which includes two afternoons of scientific presentations, is a project of the Lake Sharpe Goose Club, Inc. Additional info is available from the Great Lakes Association, P. O. Box 786, Pierre (605/224-4617).

HEALTH PLANNING GETS AUGUST AIRING

THE SO-CALLED "dog-days" of August took on a somewhat provocative flavor this year for those individuals interested in health care planning. Last month 500 or so providers and consumers of health care participated in 11 public hearings to discuss an auspicious 300-page document entitled *Draft Health Systems Plan (HSP)*.

This HSP has been a year or more in the making under the direction of the Iowa Health Systems Agency (HSA). Its preparation is federally required under Public Law 93-641.

What was the reaction to the Draft HSP in 11 scattered areas of Iowa?

Various characterizations have been given. Worthwhile. Meaningful. Bewildering. Intense. Overall, according to HSA Director John Ross, the hearings were excellent. He believes the input will be of substantial value.

On the plus side, the hearings produced a general appreciation of the need for increased efforts in personal and community health education. This is addressed in HSP goals and objectives which call for employers, schools, etc., to become more active in educational programming, in health curriculum development, etc. Also contained in the HSP were related goals to assure adequate housing, water purity, adequate immunization protection, health screening for the elderly and chronically ill, etc. While differences may exist as to how these goals are reached, few will challenge their laudatory nature.

A concern heard often during August had to do with external control and fear that arbitrarily-imposed requirements will stifle local innovation and local initiative. This reached its crescendo with respect to hospital occupancy. Understood or misunderstood, many saw the HSP as a harbinger of hospital closings. The belief emerged that should an Iowa hospital not achieve an established occupancy level, applicable to all facilities, it would be subject to closure.

HSA Director Ross has sought to clarify this issue and allay some of the concerns. He does so by describing the likelihood of as many as three

levels of in-patient care, differing in nature by their scope of services. It has been suggested the occupancy rates for primary care (smaller) hospitals could be 60% or lower with an offsetting rate of 80% or higher where secondary or tertiary care is available.

The extensive HSP has three particular goals which speak to facility use:

Goal 8—The cost of diagnosis and treatment services reflecting appropriate and efficient utilization of resources and not including costs (including operating costs) attributable to unnecessary capital investment in health care facilities.

Goal 8-1—All individuals who seek diagnosis and treatment services receiving the appropriate level of care commensurate with, but not exceeding, their medical and social needs.

Goal 8-2—No capital investment covered under certificate of need supporting diagnosis and treatment services provided in the short stay inpatient setting if the population to be served by the proposed new service has reasonable access to existing under-utilized services.

It is acknowledged these goals when lifted from their context are difficult to comprehend. They are quoted here to provide some feel for the HSP language. In addition to consideration of hospital use, the hearings included frequent comments on (a) the accessibility and availability of health care, (b) the cost effectiveness of health care, and (c) the distribution and appropriate use of health care manpower.

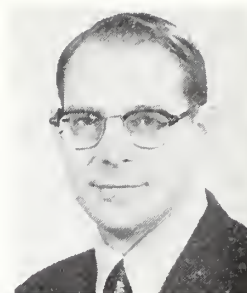
Elaboration on these goals and issues must go on and on. It is essential if understanding is to be achieved and informed positions are to be taken. The HSP is subject wisely to annual change, and while controversial in many respects it has the virtue of forcing serious thought.

The Draft HSP will be evaluated and revised based on the hearing input. It is to be considered by the five subarea councils in October. Then in November it is possible the HSA Board of Directors will approve both the HSA and its companion Annual Implementation Plan, with a potential effective date for both of January 1, 1978.

The participants in the August hearings are to be commended for their interest and involvement. Ongoing input, reaction, criticism, whatever, by the medical profession is crucial.

IN THE PUBLIC INTEREST

The Question Box



by MARTIN G. MYERS, M.D.

Dr. Myers is director of the Division of Infectious Diseases in the University of Iowa Department of Pediatrics. He has had a principal role in the development and passage of the new immunization legislation.

What length of time will be needed before the law can show definite results?

Measles appears to cycle in Iowa every 2 years. Although the law is to take effect this next school year, technically it will not be possible to strictly enforce the law until January, 1978. Thus, it is possible that disease may occur this first year, but I would expect epidemics of the proportions we have seen this year, will disappear if the law is enforced. Clearly, the effectiveness of this law will be dependent upon the compliance of the schools, the State Health Department, and, of course, ourselves as physicians.

Will the law present special and/or difficult problems for Iowa physicians?

Clearly the implementation of this law will create initial confusion and paper work for everyone who administers vaccines. It will be necessary for many families to obtain the documentation of immunization from their physicians. This means record recall and signing forms.

For the first semester (that is, the Fall of 1977) all school children in Iowa will be "pro-

visionally enrolled" in school until their immunization records can be obtained. By the beginning of the second semester (January, 1978) all children must supply documentation that they are adequately immunized against diphtheria, pertussis, tetanus, measles, polio, and rubella. The means of documentation will probably be on a form (supplied by the Health Department) signed by a physician that the child has been adequately immunized. A child who, for medical reasons, should not be immunized may be enrolled in school if his physician provides a statement that immunization would be hazardous to his or his family's health. Additionally, a child may be enrolled if he presents an affidavit fulfilling the requirements for religious exclusion.

Many children may need to be reimmunized because records are not available or because a signed immunization record cannot be obtained from someone who previously immunized the child. The schedule of recommended immunizations presented below will satisfy the requirements of the new Iowa law:

Does the new Iowa immunization law compare favorably with those in other states?

The immunization laws in other states are highly variable in their effectiveness. The law recently signed by Governor Ray is similar to the

(Please turn to page 366)

INCIDENCE OF VACCINE PREVENTABLE DISEASES IN TEXAS

	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
Measles	13411	5204	4943	8494	9585	1617	532	212	275	265
Rubella	640	2923	4363	8409	4414	1596	1129	317	370	267
Diphtheria	72	131	75	234	56	41	18	9	6	1
Polio	10	22	6	22	4	4	0	0	2*	0

* 1 imported from Mexico.

(Courtesy Texas State Department of Health).

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Educationally Speaking

by R. M. CAPLAN, M.D.

CONTINUING EDUCATION FOR YOUR HELPERS

The current flap about CME requirements for *you* may be jamming all your available circuits so much that you haven't thought about continuing education for anyone else. If so, I urge you to find or create a few more synapses for this sort of cogitation (you really do have far more than you use). Specifically, are you sufficiently supportive—you ought to be insistent—of active and appropriate continuing education for your office and hospital helpers? The continuing education ("in-service training" it's often called) of the hospital personnel is often looked after by the hospital administrator. But even there it wouldn't be such a bad idea for the medical staff to express its interest by asking the administrator to review for the medical staff your local program of in-service training.

The more likely failing is continuing education at your office, and maybe that's the more serious one since most of you spend most of your professional time there. Both you and your patients are critically dependent on the personnel support system you provide at your office. Even a small solo office today has at least two or three employees who interact not only with you but with your patients and with all the other forces and agencies of that "outer world." Do you want their jobs to be done well? Of course. Then how do you arrange for it to be done well and keep on being done well? I suggest two procedural steps:

Step 1: Provide educational opportunities—talk with your helpers about what you do and why certain things happen as they do; bring read-

ing material that you find in your own reading and travels; suggest formal course work in nearby night school, community college or University (such as a course on "medical vocabulary" or "human relations" or even Shakespeare) and offer to pay the tuition as enticement and fringe benefit. And how about suggesting that your helpers become active in the nearby chapter of the American Association of Medical Assistants (AAMA)? With six chapters in Iowa, they meet for educational advancement and are impeded by a large mountain of apathy on the part of our physicians. As much as anything else, such activities as mentioned would convey to your helpers that you're interested in having competent, professionally alert people working for you and with you, and that you're interested in them as persons who need stimulation and growth just as you do.

Step 2: Monitor their work and their progress. Again, talk with them about their work, what they do, and how they do it. Invite their identification of problems, and brainstorm with them about possible solutions. Observe random samples of their behavior and output, and make periodic efforts to discuss your positive-tone and occasional negative-tone observations with them. If your assistant has enrolled in "medical vocabulary," make a point of chatting about some of the words and insights gained; you may learn something too. If it's Shakespeare, invite some comment—it's almost a sure thing there's something you can learn there. If she/he has joined the AAMA, chat about the meeting activities and whether she/he's making progress toward becoming a certified medical assistant. And yes, if all this costs you some money and time, I submit it would be money and time well spent.

The continuing education of your helping colleagues of *all* types is important to *you*.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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SCIENTIFIC ARTICLES

Tammy and Calico: Acquired Toxoplasmosis With a Probable Cat Transmission Mode

JULIUS S. CONNER, M.D., M.P.H., and

CHARLES R. PETERSON, M.D.

Des Moines

An increase in lowans contacting toxoplasmosis has been reported in recent years. This case involved an exhaustive diagnostic effort. Exposure was traced to soil contaminated by cat feces.

Toxoplasma gondii, the protozoan parasite, is widely distributed throughout the world, infecting man as well as many species of animals and birds.¹

Twelve human cases of toxoplasmosis were reported by physicians to the Iowa State Department of Health during 1975.² Physician requests to the Iowa State Hygienic Laboratory for toxoplasmosis serology increased by 44% during the two fiscal years 1975 and 1976.³ Of 1,210 sera tested during the 12-month period ending March 3, 1975, 237 (20%) had an indirect fluorescent antibody titer of 1:16 or greater. The per cent reactivity by age groups increased progressively from 15% for children and young adults to 47% for persons over 60 years of age.

In most human infections with *Toxoplasma gondii*, the mode of transmission is unknown.⁴ The organism crosses the placental barrier to cause congenital infections in approximately one of every 3,000 newborns; may be transmitted with raw or under cooked meat; and occasionally infects laboratory workers who handle cat

feces containing oocysts. The relative importance of cats in the natural transmission of toxoplasmosis remains unquantified.

This article describes the clinical course of acquired Toxoplasmosis as it affected Tammy, a pre-school child. It also relates the epidemiological investigation undertaken in an attempt to discover the source of the infection and its probable transmission to the child by Calico, a stray cat.

TAMMY

The patient is a 5-year-old girl with a past history of slow growth velocity and frequent respiratory tract infections. Tammy weighed 2934 gm (6 lb 7½ oz) at birth. However, her subsequent growth has been below the 3rd percentile. Her current measurements of 12.7 kg and 89 cm correspond to a weight and height age of 2½ years. Parents and siblings are of average size with heights of 164 cm or more. Tammy sat alone at 8 months and walked without assistance at 14 months.

Tammy's frequent respiratory tract infections require immediate attention by her physician to

Dr. Conner is Director of the Des Moines-Polk County Department of Health. Dr. Peterson is in the private practice of family medicine in Des Moines, Iowa.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS
THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF SEPTEMBER 1977.

avoid a prolonged convalescence or hospitalization. Gamma globulin substitution therapy has been used since infancy with helpful results. She was hospitalized with bronchitis at 4 months; gastroenteritis at 8 months; adenotonsillectomy at 2½ years; and a urinary tract infection associated with a urethral stricture at 5 years.

Both the father and a 15-year-old brother have thalassemia minor. Tammy has a normal hemoglobin electrophoretic pattern.

Tammy's present illness began July 27, 1975 with the development of nausea, vomiting, runny nose, sore throat, fever and cough. Other family members remained well. She was given an injection of penicillin on the same date, when an emergency room physician diagnosed her condition as a mild otitis media. By July 29, the fever had increased to 104 F and was associated with lethargy. Hospitalization was advised by her family physician.

Physical findings on admission were redness of the nose and throat, swelling and tenderness of the cervical lymph nodes, coarse breath sounds from both lungs and hyperactive bowel sounds. There was no rash, stiffness of neck, liver enlargement or abdominal tenderness on the admission date.

LABORATORY FINDINGS

Laboratory studies revealed a hemoglobin level of 11.3 gm/100 cc, and a white blood count of 4,800/cu mm. Band cells (40%) and several young granulocytes were present in her peripheral blood smear. Bone marrow aspirated from her iliac crest showed granulocytic hyperplasia. No leukemic cells were seen. Repeated blood and urine cultures were negative for pathogenic bacteria. Urine analyses were negative. Stool tests for pinworms and other parasites were negative. Sinus and chest x-rays as well as intravenous pyelograms were read as normal.

Normal values were obtained for the L.E. preparation, fluorescent antinuclear antibody test, and febrile agglutinins. Quantitative immunoglobulins IgA, IgM, and IgG were also normal. Liver function tests disclosed low total protein and albumin values associated with elevation of S.G.O.T. (159 mU/cc), L.D.H. (387 mU/cc), and alkaline phosphatase (180 H.U./cc). Total serum bilirubin, urine bile and porphyrins, heterophil antibody titers and hepatitis B antigen test by counterelectrophoresis were normal.

Tammy ran a septic clinical course for three days after admission. On July 31, a nonpruritic

maculopapular rash spread from her face to her body, and severe right upper abdominal tenderness with guarding developed. Pediatric and surgical consultants agreed with the family physician that an exploratory laparotomy was indicated to detect subhepatic or appendiceal abscess or other intra-abdominal sepsis.

Tammy's abdomen was explored through a transverse incision made in the right flank. Only a small amount of serous fluid was observed. Her liver was enlarged, soft, smooth, and of normal color. No portal hypertension existed. The mesentery, right kidney, pancreas, gastroduodenal area, small and large bowel were also normal. An incidental appendectomy was performed. The serous fluid was negative for pathogens on both gram stain and culture. A needle biopsy of the liver during surgery revealed a well preserved but edematous lobular architectural pattern. A moderate amount of chronic inflammatory infiltrate consisting mainly of lymphocytes, a few eosinophils and plasma cells was present in the portal triads. Her appendix was not inflamed and contained neither parasitic nor neoplastic elements.

A diagnostic rise in antibody titer to *Toxoplasma gondii* was demonstrated. The acute serum drawn August 1, had a titer of 1:32. The convalescent serum drawn August 12 was read as 1:2048. No detectable antibody titer was found to cytomegalovirus, influenza A and B, adenovirus, Eaton's agent and Histoplasma. Although ECHO virus 4 was isolated from the stool, no antibody was detected in the acute or convalescent serum.

Tammy's fever, rash and lethargy gradually subsided by August 4, her ninth day of illness. Ampicillin was administered during the first three days. Specific treatment for toxoplasmosis was not given because Tammy had already recovered from her acute illness by the time the diagnosis was confirmed by serologic studies.

CALICO

One year prior to Tammy's illness, a stray cat delivered a litter of kittens near the family's backyard greenhouse. After weaning had been accomplished, the cat family departed. However, one of the kittens with calico markings returned regularly and was befriended by Tammy.

Eight days prior to Tammy's illness, Calico was noted to be ill with a conjunctival discharge and a counterclockwise circling gait. When Tammy's acute febrile illness failed to respond to

antibiotics, the family physician requested an examination of the cat. A private veterinarian practicing in the Des Moines area gave the cat its initial examination. Anemia, conjunctivitis, and an ear infection were the major findings. Because of the increasing seriousness of Tammy's condition, the cat was transferred to Iowa State University College of Veterinary Medicine for additional studies.⁵

On presentation, the cat was anemic with a hookworm infection. The nictitating membrane of the left eye was constantly protruded. The cat circled to the left as if the right eye were blind. A complete blood count was normal. The cerebrospinal fluid revealed numerous crenated red blood cells suggesting previous hemorrhage into the meninges as a result of cranial trauma. Radiographs of the neck and head were normal. An agglutination test for *Leptospira pomona*, icterohemorrhagiae, canicola, hardjo, and grippotyphosa were negative. Two *Toxoplasma* antibody titers three weeks apart showed titers of 1 : 128 and 1 : 256 by indirect fluorescent antibody tests.

Mice inoculated with cat specimens were found to be negative for streptobacillus and spirillum organisms.

EPIDEMIOLOGICAL INVESTIGATION

Tammy and her family live in a small urbanized area just southeast of the Des Moines city limits. Ingestion of raw or rare meat was never practiced by the family. Blood drawn from both parents and a sibling living at home was negative for *Toxoplasma* antibody. Smokey, the family's cat of 15 years, has not been allowed outside the house during the past five years. The cat's serum was also negative for *Toxoplasma* antibody.

Health Department humane officers searched the neighborhood for additional stray cats who might have been infected along with Calico. Six were apprehended by January 1976 and forwarded for testing to the College of Veterinary Medicine, Iowa State University. Two cats had serum *Toxoplasma* antibody titers of 1 : 1024; one cat had a titer of 1 : 512; and two cats had titers of 1 : 256. A titer of 1 : 16 is considered to be of diagnostic significance in the indirect fluorescent antibody test employed; 1 : 16-1 : 64 indicates recent or remote exposure; and 1 : 256 or greater is evidence of recent involvement. One of the six cats was not tested for serum antibody but had intestinal schizonts which were morphologically consistent with *Toxoplasma*. Several of the

cats were litter mates of Calico.

Samples of dirt were taken from the greenhouse, sandbox and other areas where Tammy may have been exposed to soil contaminated with cat feces. The seven soil samples were negative for *Toxoplasma* oocysts on both microscopic examination and mice inoculation. However, *Eimeria* oocysts and nematode ova were identified by the microscopic examinations. The tests were performed in July, 1976 at the Iowa State University Veterinary Medical Research Institute, about one year after Tammy's illness.

Neighborhood residents reported seeing stray cats carrying dead mice to their kittens in August, 1975, and again in April, 1976. Health Department sanitarians conducted a yard to yard environmental survey looking for sources of food, water or shelter suitable for rats. Only one potential rat harborage was found. Vector control specialists from the Health Department examined each property for evidence of rat infestation. None was found. During the week of April 12-19, 1976 baited rat traps were placed in two salvage yards which border the neighborhood. No mice or rats were trapped.

DISCUSSION

Acquired toxoplasmosis was manifested in Tammy as a systemic illness characterized by fatigue, fever (104 F), coryza, cervical lymphadenopathy, maculopapular rash, severe abdominal tenderness and hepatomegaly. The marked rise in indirect fluorescent antibody titer (1 : 32 to 1 : 2048) in the child accompanied by an absence of antibody in the mother supports a diagnosis of the acquired form of the disease rather than a recrudescence of congenital toxoplasmosis. This child's past history of frequent respiratory tract infections, necessitating regular gamma globulin injections suggests a deficiency in cellular immunity which would explain why the disease manifested itself clinically in her case. Most acquired toxoplasmosis infections in healthy persons are subclinical.

Transmission of *Toxoplasma* organisms to this girl was probably the result of oocyst ingestion from playing in soil contaminated by feces from Calico. Stool from the cat was consistently negative for oocysts, however, a *Toxoplasma* antibody titer high enough to indicate recent infection was demonstrated in the cat's serum. Oocysts, the infective stage of the parasite, are excreted by cats for only a short period of time (about two weeks) beginning seven days after

the animal itself has become infected, but they may remain viable in shaded moist soil for many months.⁶

Tammy's diagnosis of toxoplasmosis was not confirmed until the report of the convalescent serum *Toxoplasma* antibody titer was returned on the twentieth day after the onset of her illness. By that time, she had recovered. Drugs commonly used in the treatment of toxoplasmosis, pyrimethamine (Daraprim), and sulfadiazine, may give rise to thrombocytopenia and leukopenia.

Frequent monitoring of the peripheral blood elements is required to detect bone marrow depression.⁷ This patient is allergic to sulfa drugs. However, had the disease process continued, treatment with pyrimethamine alone or the use of tetracycline or lincomycin would have been considered.

Prevention of toxoplasmosis is particularly important for two groups of people. Pregnant women—without antibody titer—are at risk of transplacental transmission of tachyzoites to the fetus where abortion or congenital anomalies may result. Cancer patients on immunodepressant drugs and others with deficiencies in their immune mechanism are at risk of developing clinical illness upon exposure, or a recrudescence of an earlier infection.

Practical advice for those who are pregnant or immunologically deficient would be to avoid ingestion of raw meat and delegate to others the removal of excreta from house cats fed raw meat or who also forage.⁸

ACKNOWLEDGEMENTS

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Public Acceptance of Iowa Family Practice Centers

FRANK G. WILLIAMS, Ph.D.

Iowa City

What do the people who visit family practice centers think of them? This paper is based on a survey of attitudes of those citizens using four Iowa FPC's. According to the author, success of family practice as a medical specialty, will depend partially on the viability of the FPC as an educational site.

THE FAMILY PRACTICE CENTER (FPC) is an educational facility that simulates the typical family physician's office. Iowa family practice residency programs have found FPC's most beneficial to teaching and research. Location of FPC's in areas of physician shortages has helped alleviate primary care needs. Early indications are that the exposure of residents to Iowa communities is encouraging some to remain in these areas after completion of their residencies.

Unfortunately, the early contributions of FPC's to quality education, patient care, and research have too often been overshadowed by logistical and attitudinal difficulties. Public priorities are frequently different from those of educational programs. Nevertheless, utilization and support of FPC's by those in the communities in which the FPC's are located is critical to their success.

Public satisfaction and acceptance of care given by Iowa FPC's was evaluated by a questionnaire in November, 1974. Three hundred were

randomly mailed to each of four communities.¹ As indicated in Table I, the communities were selected to provide data on both university and community hospital-based FPC's located in areas of small, moderate, and large populations.

SATISFACTION

The summary of ratings reported in Table II indicates overall approval of FPC personnel. Participants were requested to comment and offer suggestions concerning their community's FPC. Most written responses were also positive, but there were complaints concerning those practices which, for educational purposes, differ from idealized private practice. The change of residents as they complete their program or rotate out of town was the most significant. Less than half gave a favorable response to the question, "How well does the (name of FPC) do in making sure you are seen by the same doctor on every visit?" ("Good"—67; "O.K."—42; "Poor"—31; "Don't Know"—36).

Waiting time for patients after they arrive was another factor which brought negative reactions ("Good"—85; "O.K."—73; "Poor"—52; "Don't Know"—2). Much of this problem can be attributed to complexities in scheduling. The relatively short tenure of each resident makes it difficult for faculty and staff to learn the amount of time that should be allotted for each type of activity for each resident. These initially inexperienced physicians are continually modifying their procedures and improving their efficiency. Adjustments tend to be perpetually obsolete.

It is difficult to avoid situations where residents, and therefore their patients, are waiting for faculty who are consulting with other residents. If medical students, nursing students, physicians' assistants, or others in training are also present, the problem is further complicated. Dif-

Dr. Williams conducted the study on which this paper is based during graduate study at the University of Iowa. The author is now associated with the Center for Health Services Administration at Arizona State University, Tempe, Arizona 85281.

TABLE I
SURVEY RESPONSE

FPC*	Community Population	Base of Residency Program	Return (N = 300 each)
A	1,000	Community Hospital	163 (54.3%)
B	1,800	University Medical School	118 (39.4%)
C	30,000	University and Community Hospital	85 (28.3%)
D	100,000	Community Hospital	98 (32.7%)
Total			464 (38.7%)

* FPC's A & D are jointly sponsored by two large community teaching hospitals. FPC D is their primary teaching practice. FPC A is a rural branch. FPC B is a rural satellite of the University program. FPC C is also sponsored by the University and by the community teaching hospital near which it is located.

difficulties occur when residents are delayed while treating patients in other departments and while traveling to and from the FPC.

Logistical factors other than the rotation of residents and scheduling difficulties are sufficiently managed by FPC's according to the survey. Respondents who had visited an FPC gave positive ratings to convenience variables affecting their satisfaction. FPC locations, hours, and ease of getting an appointment were not objectionable to most patients.

UTILIZATION

The most obvious reason why people would not visit a new FPC is their already established positive relationship with a private physician. A statement that respondents already had their own doctors was not included on the questionnaire since it might be misconstrued. Instead, a list of FPC characteristics that could inhibit utilization was presented. These statements and the number who checked "true" to each are delineated in Table III.

Communities without adequate physician coverage have given their FPC good visibility via local newspaper and television coverage. Nevertheless, Table III shows that 103 of 235 persons responded they were not aware of an FPC. Other

were confused about the purpose of their FPC, or did not realize it was open to the public. Many in the larger communities, particularly, had the impression that FPC's are only for the poor or other specific population groups.

Early in the development of the questionnaire it was recognized that some people would not visit FPC's because they do not visit any physician's office. This number was expected to be relatively high due to physician shortages, costs, and perhaps because of changing cultural values. However, only 13 of 235 responded "true" to the statement, "You do not visit physician's offices for health care," as noted in Table III. Interestingly, however, even though only these 13 were asked to answer a follow-up question on why

TABLE III
REASONS FOR NONUTILIZATION OF FPC'S
(N = 235)

N*	
13	You do not visit physicians' offices for health care.
103	You did not know the Family Practice Center existed until you received this survey.
97	You did not know the Family Practice Center was open to the public.
22	You do not believe the Family Practice Center is for you because you do not have a family.
5	You had been led to believe that Family Practice is the same as Family Planning.
22	You would rather see specialists other than Family Physicians for your medical care.
75	You would rather see private physicians instead of those in teaching programs.
1	You tried, but were not able to get an appointment at the Family Practice Center.
11	You probably would visit the Family Practice Center if it were in a more convenient location.

* Number responding "true" to each statement.

TABLE II
PATIENT EVALUATION OF FPC PERSONNEL

	"Good"	"O.K."	"Poor"	"Don't Know"
Office Staff	191	39	4	1
Allied Health Personnel	141	34	2	5
Nurses	187	36	0	0
Physicians	185	30	7	1
	704	139	13	7

TABLE IV
CONTINUATION OF DEMAND FOR MODEL
OFFICE SERVICES*

FPC	"Yes"	"No"	"Undecided"
A	110	5	14
B	71	1	15
C	2	0	2
D	4	0	0
	187	6	31

* Responses given to the question, "Do you and/or your family intend to continue to visit the (name of FPC)?"

they do not visit physicians' offices, 53 checked "true" the statement that they visit hospital emergency rooms or other clinics when necessary. Apparently, although a majority of respondents do visit physicians' offices, a significant proportion wished to point out they also find it desirable or necessary to visit hospital emergency rooms and clinics.

It is assumed the emergency rooms and clinics are most often necessary for evening and weekend emergencies and when private physicians cannot accept any more appointments. This study suggests a key variable to the acceptance of an FPC by the general public is its ability to provide emergency service outside of regular office hours.

One speculation occasionally heard is that consumers are less than satisfied with FPC's not only because they are part of teaching programs, but because most patients now prefer traditional specialists over family physicians. The results of the study however, demonstrate that family physicians are preferable by a wide margin. The preference for family physicians by over 90% of all those who responded shows definite support of the family practice concept in Iowa.

The survey concluded with questions to assess the overall attitude of consumers toward FPC's. These results, reported in Table IV, are very decisive. Only 6 of 224 persons stated they would no longer visit their FPC. Adjustments for educational and research purposes are not usually appreciated by patients, as noted earlier. However, it is apparent that these changes do not cause a refusal to visit FPC's when other sources of primary physician care are not readily available.

Estimations of general community support were also obtained by asking those who have not visited an FPC if they thought the family practice

center was a good idea. Their responses are provided in Table V. To the extent that some persons were initially neutral toward the FPC concept the data suggest that family practice centers have gained public support.

IMPLICATIONS AND CONCLUSIONS

Nearly everyone in the Iowa communities surveyed expressed support for the family practice concept, the education of more family physicians, and the development of family practice centers. However, many believe that their acceptance and support implies a commitment from residency programs to provide a complete range of services at all times irrespective of educational obligations.

As with the establishment of any practice, supply and demand factors should be considered in the location of FPC's. However, faculty must be

TABLE V
NONPARTICIPANTS' SUPPORT OF FPC'S*

FPC	"Yes"	"No"	"Undecided"
A	29	0	1
B	17	3	6
C	52	0	24†
D	67	0	17†
	165	3	48

* Responses given to the question, "Do you think the FPC is a good idea?"

† Most of these "undecided" responses were given by persons who also stated they did not know the FPC existed until they received this survey.

wary when placing FPC's in small communities until it can be demonstrated that permanent physicians can be attracted. Otherwise, they may engender never-ending responsibilities for patient care and face pressures to adjust educational goals to meet public health care expectations.

The preferred location for FPC's is the larger community that already has a modest proportion of primary care physicians. These physicians will continue to serve the majority of consumers who want permanent physicians. The FPC's would then be available to those who prefer the relatively long periods of time spent with each resident physician, the quality control and review provided by faculty and staff, and the other elements associated with an educational and research environment.

The family practice center is a vital element in the education of family physicians. From this perspective, the ultimate success of family prac-

tice as a medical specialty depends in part on the feasibility of the FPC in graduate education. This study indicates that the FPC is a viable concept in Iowa.

NOTES

1. A return of 100 questionnaires from each community was required to achieve 0.05 significance, $P(|p-P| \geq 0.10) \leq 0.05$,

$n = 100$. Previous experience indicated a one-third rate of return could be expected, so 300 were sent to each community.

ACKNOWLEDGEMENTS

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Temporary Tube Gastrostomy: A Five Year Study

JOSE A. OLIVENCIA, M.D., and

ROMEO S. BERARDI, M.D.

Des Moines

TUBE GASTROSTOMY, whether employed primarily for decompression or specifically for feeding purposes, has been advocated for a long time as a valuable procedure in the management of certain patients. Some advocates¹⁻³ of gastrostomy have concluded there is little reason to employ nasogastric suction in the postoperative period with the many advantages of gastrostomy.

Among the many indications for gastrostomy, its use for postoperative decompression in patients with chronic pulmonary obstructive disease has been widely acclaimed as a means of decreasing pulmonary complications almost to complete elimination. This appears to be reflected in the literature since most, if not all, complications related to tube gastrostomy have been due to an error in technique, to the local wound or to the tube itself.⁴⁻¹⁰ One notes a conspicuous lack of pulmonary complications directly related to gastrostomy.

Since tube gastrostomy, when used for postoperative decompression, is generally a much smaller part of a more extensive procedure, it would appear that whenever a pulmonary complication ensues, difficulty may arise as to which

This study of 130 VA patients attempts to assess the degree of direct relationship between known pulmonary complications and gastrostomy itself. The value of the procedure is generally supported.

procedure is directly related to the complication.

This institution, as well as one of the authors (RSB), has used gastrostomy in the management of many surgical patients over the years. Since pulmonary complications are known to have occurred in some of these patients, a retrospective study was undertaken to cover the five-year period, 1970 through 1974. Purpose of the study was to determine if any direct relationship could be established between known pulmonary complications and the gastrostomy itself.

MATERIALS

One hundred and thirty consecutive male patients having a tube gastrostomy were included in the study. The average age for the entire group was 61.3 years, with the youngest 23 years and oldest 85 years. Age distribution is recorded in Table 1. One hundred (76.8%) patients were over 50 years of age.

Patients were divided into two major groups. Group I consisted of 100 patients who had decompression gastrostomy associated with other operations (Table 2). Group II consisted of 30 patients where gastrostomy was performed solely for feeding purposes, although some patients in

(Please turn to page 363)

Dr. Olivencia is a senior surgical resident at the Veterans Administration Hospital in Des Moines, Iowa. Dr. Berardi is assistant section chief, General Surgery, at the Des Moines VA facility, and clinical associate professor, University of Iowa.

TABLE I
AGE DISTRIBUTION*

	No. of Patients	Per Cent
20-30	4	3.1
30-40	3	2.3
40-50	23	17.7
50-60	29	22.3
60-70	28	21.5
70-80	29	22.3
80-90	14	10.8
	130	100.0

* Average age 61.3 years, range 23 to 85 years.

this group also had instrumental diagnostic and therapeutic procedures. The indications for a feeding tube gastrostomy in these patients are listed in Table 3.

Significant associated diseases encountered in all patients are ranked in Table 4. Some of these diseases constituted the primary indication for gastrostomy. Arteriosclerotic heart disease and chronic pulmonary obstructive disease were the two most common associated diseases, both of them being characteristic of our VA patient population. Significant associated diseases found in patients in Group II are ranked in Table 5.

DATA ON GASTROSTOMY

All gastrostomies performed in Group I were done so at the end of other major operative procedures and, therefore, under general anesthesia. The gastrostomies performed in Group II were for the most part done under local anesthesia, with the exception of eight done under general anesthesia.

A Stamm gastrostomy was executed in most patients with 22 (16.9%) patients having a Dragstedt modification.⁷ That is, all stomachs were sutured to the anterior peritoneum of the abdominal wall. In the Dragstedt modification, omentum was interposed between the stomach and anterior peritoneum without suture fixation of the stomach.

A 20-24 caliber Foley catheter was used in 98 (75.5%) patients. An average of 8 cc of saline was used to inflate the balloon. A Horwitz tube was used in 17 (13.1%) patients; a Malecott tube in 2 (1.5%) patients, and a straight Robinson in 4 (3.1%) patients. The type of tube employed in 9 (6.9%) patients was not stated.

Absorbable sutures of 2-0 chromic catgut were

used as a double row purse string suture in the stomach wall in 56 (43.7%) patients. In 50 (38.5%) patients, nonabsorbable suture was used. The suture material employed in 24 (18.5%) patients was not mentioned.

The gastrostomy tube was removed on the average after 14 days with a range of 5 days to 66 days.

COMPLICATIONS

Complications resulting in each of the groups and considered directly related to gastrostomy are recorded in Tables 6 and 7.

Group I

Nine complications were registered in Group I accounting for a morbidity rate of 9 per cent. Seven of the 9 complications were related to the gastrostomy wound and/or gastrostomy tube.

TABLE 2
OPERATIONS PERFORMED
GROUP I

Procedure	No. of Patients
Gastric	58
Biliary	13
Small bowel	11
Colonic	10
Esophageal	4
Appendectomy	1
Esophageal dilatation	1
Vascular	1
Pancreatic	1
	100

TABLE 3
GASTROSTOMY
GROUP II

Indications	No. of Patients
Oral cancer	7
Esophageal cancer	5
Laryngeal cancer	4
Cerebral thrombosis	3
Esophageal stenosis	3
Pharyngeal cancer	2
Chronic brain syndrome	1
Esophageal perforation	2
Multiple trauma	1
Multiple sclerosis	1
Lateral amyotrophic sclerosis	1
	30

TABLE 4
SIGNIFICANT ASSOCIATED DISEASES

Rank	Type	No. of Patients
1	Chronic pulmonary obstructive disease	36
2	Arteriosclerotic heart disease	35
3	Benign prostatic hypertrophy	10
4	Liver cirrhosis	9
5	Diabetes mellitus	8
6	Chronic brain syndrome	8
7	Cerebral thrombosis	6
8	Schizophrenia	6
9	Hiatal hernia	6
10	Esophagitis	4
11	Obesity	4
12	Convulsive disorder	2
13	Prostatic cancer	1
14	Multiple sclerosis	1
15	Parkinson's disease	1
16	Myopathy	1

One patient who underwent cholecystectomy experienced significant postoperative gastric bleeding and died. Necropsy revealed severe erosions in the area of the Foley catheter balloon. A second patient with a cholecystectomy experienced minimal postoperative gastric bleeding but died. Necropsy in this case revealed massive thrombosis of the hepatic veins and bilateral bronchopneumonia.

The two patients in Group I with clinical evidence of aspiration pneumonitis both died, one after gastric surgery for pyloric obstruction and the other after lysis of adhesions for small bowel obstruction. Both patients required prolonged gastric drainage. These two complications most likely resulted from inadequate gastric decompression and drainage.

TABLE 5
SIGNIFICANT ASSOCIATED DISEASES
GROUP II

Rank	Type	No. of Patients
1	Arteriosclerotic heart disease	5
2	Chronic pulmonary obstructive disease	3
3	Chronic brain syndrome	2
4	Diabetes mellitus	1
5	Convulsive disorder	1
6	Benign prostatic hypertrophy	1
7	Myopathy	1
8	Liver cirrhosis	1

It is interesting to note that Group I patients had an additional 12 pulmonary complications registered either as bronchopneumonia and/or atelectasis but not regarded as being directly related to gastrostomy. The difficulty in this differentiation is obvious. The patient with a non-functional gastrostomy tube required nasogastric drainage and developed bronchopneumonia post-operatively.

Group II

Six complications were registered in Group II among 6 patients, accounting for a morbidity rate of 20 per cent. Of these complications, four were pulmonary in nature and were considered to be related to gastrostomy since no other operative procedure was employed. However, further analysis reveals two of the pulmonary complications occurred in patients with head and neck tumors and who were unable to swallow and adequately clear their oropharyngeal secretions; one had an esophageal carcinoma; and the fourth had an ineffective oropharyngeal reflex after sustaining a cerebral thrombosis. All are entities known to be frequently associated with pulmonary complications.

Two of the four pulmonary complications were, however, aspiration pneumonitis. Because of this they must be considered related to the gastrostomy. This was particularly evident in one patient in that some feeding given via the gastrostomy tube was recovered in the tracheo-bronchial airway. Both patients died.

Two additional patients, who died of carcinoma, had evidence of aspiration pneumonitis at necropsy. Both patients had been taking regular feedings via the gastrostomy tube.

It is interesting to note a total of 34 deaths occurred in these 130 patients; 23 in Group I and 11 in Group II. This gives some indication of the type of patients making up the groups in whom gastrostomy was performed. Many of the patients in Group I for example had emergent operations. Many of the patients in Group II were being treated for advanced cancer.

DISCUSSION

When temporary tube gastrostomy is employed in aged, obese patients with chronic bronchitis and emphysema, who otherwise have an uncomplicated primary disease and surgical intervention, the general consensus as to a decrease in pulmonary complications through the use of tube

gastrostomy for decompression (as compared to a nasogastric tube) may indeed be correct.

The same results, however, are not as striking or apparent when gastrostomy is used in aged patients presenting with pre-existing pulmonary disease and with a complicated primary disease where emergent operative intervention is often required. When these characteristics are further combined with still other significant associated diseases, then serious pulmonary complications become a clinical reality¹¹ as clearly demonstrated in this study. Although the adverse effects of nasogastric drainage^{1, 3, 9} are eliminated with the use of gastrostomy, it would appear that pulmonary complications still remain a serious problem in at least certain patients.

This study further demonstrates the difficulty one has in deciding whether a pulmonary complication is directly related to gastrostomy. Because of age, the nature of the primary disease, the seriousness of associated diseases, prolonged postoperative course, etc., many in the study were necessarily immobile longer than one anticipates in less seriously ill patients in whom gastrostomy is used for decompression. Furthermore, many patients had serious mental disorders which were not conducive to optimal patient cooperation in the postoperative period.

The patients comprising this study are not necessarily comparable to those in other centers. Of the patients, 76.9 per cent were over 50 years of age and 33.1 per cent were over 70 years. Of the operations performed in Group I patients, well over one-fourth were of an emergent nature. Of the indications in Group II patients requiring a feeding gastrostomy, 18 were for advanced head, neck or esophageal cancers. Many of the associated diseases encountered in these patients, as well as the primary diseases, are known to be allied with a relatively high incidence of pulmonary complications.

Nevertheless, when aspiration pneumonitis occurs in patients in whom gastrostomy has been employed, it would appear logical to assume such a complication is related to the gastrostomy whether due to inadequate decompression and/or mismanagement in tube feedings, at least in some cases.

That technical difficulties with gastrostomy have been, and are a continuing problem and source of dissatisfaction, is attested to by the numerous articles written about improved techniques, tubes, and management.^{8, 11-21} Further-

TABLE 6
COMPLICATIONS
GROUP I

Type	No. of Patients
Wound infection	
Minor	3
Major	1
Non-functioning tube	1
Gastric bleeding*	
Major	1
Minor	1
Pulmonary*	
Aspiration	2
	<hr/> 9

* Both patients died.

more, almost all recorded complications in the literature concern some technical aspect of the gastrostomy procedure or tube itself. The complications in this study accounted for 9 of the 15 complications encountered.

We continue to be quite aware of the possibility that aspiration pneumonitis does occur with gastrostomy whether used for decompression or for feeding.²² Although this complication may be due to inadequate gastric decompression or management, this study should be of interest to those who use gastrostomy and those who share responsibility for the management of this patient. This is especially important because the overwhelming number of articles in the literature dealing with gastrostomy fail to mention such a complication and give the impression that pulmonary complications have all but been eliminated.

TABLE 7
COMPLICATIONS
GROUP II

Type	No. of Patients
Wound infection	
Minor	2
Pulmonary	
Aspiration*	2
Bronchopneumonia	2
	<hr/> 6

* Both patients died.

We continue to employ gastrostomy in certain patients, especially those who are (a) seriously ill, (b) need prolonged gastric drainage, (c) have disease entities which make it a more feasible procedure for drainage, and (d) have significant associated disease, etc. We do the preceding with the utmost respect for what is in reality a simple procedure but which can be directly related to serious, and at times, fatal complications.⁴

QUESTION BOX

(Continued from page 351)

law in Texas which has proven to be most effective. By limiting the exclusions to just those children with medical contraindications and those with religious objection, almost all school children will be immunized. The absence of a so-called "conscience exclusion" in this bill will make it enforceable and thus effective. It is clear, that in many states immunization laws are not terribly effective because they are not enforceable.

Will the law have a definite impact on the presence of communicable diseases?

Only time can test this question adequately. However, if the experience in other states is comparable, we have hopefully seen the last major epidemic of measles in Iowa. The effectiveness of a similar law in Texas enacted in 1971 is outlined in the table below.

CONCLUSION

A five-year study of patients having temporary tube gastrostomies has been presented. Some aspects of this procedure, especially those related to pulmonary complications, have been discussed.

REFERENCES

The references noted in this article are available on request either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

RECOMMENDED SCHEDULE FOR ACTIVE IMMUNIZATION OF NORMAL INFANTS AND CHILDREN

2 mo.	DTP, TOPV
4 mo.	DTP, TOPV
6 mo.	DTP, TOPV
15 mo.	Measles, rubella, mumps
1½ yr.	DTP, TOPV
4-6 yr.	DTP, TOPV
14-16 yr.	Td; repeat every 10 yr.

PRIMARY IMMUNIZATION FOR CHILDREN NOT IMMUNIZED IN INFANCY

15 Months Through 5 Years of Age

First visit	DTP, TOPV
1 mo. later	Measles, rubella, mumps
2 mo. later	DTP, TOPV
4 mo. later	DTP, TOPV
6-12 mo. later or preschool	DTP, TOPV
Age 14-16 yr.	Td; repeat every 10 yr.

6 to 12 Years of Age

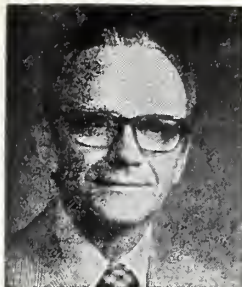
First visit	Td, TOPV
1 mo. later	Measles, rubella, mumps
2 mo. later	Td, TOPV
6 to 12 mo. later	Td, TOPV
Age 14-16 yr.	Td; repeat every 10 yr.

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Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

September 15-16	Conference on Pediatrics
September 16	Otolaryngology Clinical Conference
September 16-17	Iowa Society of Anesthesiologists
September 16-17	Urology Postgraduate Conference
September 16-17	Dermatology for Dermatologists
September 19-28	The Andrew Woods Psychiatry Professorship Series
September 21	Diet Therapy U.S.A.

September 22	Radiation Therapy Seminar
September 23-24	Iowa Academy of Ophthalmology
September 24	Mini-Sports Medicine Conference
September 25	Fitness Concepts for the Health Professional
October 3-6	Cardiology Today
October 6-8	Training Institute for Physical Therapy Supervisors
October 8	Neurology Update: Current Diagnosis and Therapy



Editorials

M. E. ALBERTS, M.D., Scientific Editor

FRINGE BENEFITS AND SOLO PRACTICE

Management-employee negotiations include much consideration over fringe benefits. Many hours of debate are devoted to these unseen benefits as well as the basic pay. Often the worker is not totally aware of the actual value of the extra benefits. A survey of more than 3,000 employees of an Eastern manufacturing plant revealed amazingly little awareness of the percentage of payroll allocated to fringe benefits. Over 60% of the employees estimated 10% or less for fringes, while another 24% answered 5% or less. Only 2% estimated as high as 30%. Actually, the fringe benefits amounted to 31.7% of the total payroll.

Most employees cannot list many of the fringe benefits they receive. Some of these are tangible, others the employee may not be aware of or does not realize are truly benefits. Coffee breaks or chatting with another employee, while accomplishing nothing, represents non-productive time for the employer. Other benefits such as group insurance and hospitalization, retirement benefits, paid vacations, holidays, parking lot facilities, overtime pay, employer's contributions to Social Security, and unemployment compensation contributions amount to many dollars. The individual owner-manager derives only the satisfaction that such expenses are tax deductible business expenses. So it is with the self-employed physician. His vacations are without compensation—in fact, they entail more than loss of income because the overhead continues. There is no time-and-a-half for overtime. Sundays and holidays are not different from traditional workdays.

It is not surprising then that many physicians have abandoned solo practice for group practice or employment by corporations or large clinics, like governmental bureaus, or academic institu-

tions. Security is the name of the game—security with more freedom to live as other people.

The solo practitioner has fringe benefits, too. His lot in life is not entirely a “nose to the grindstone” existence. He has a freedom the employee-physician cannot measure in cash equivalents. Life is a complex endeavor, constantly involving interaction directly or indirectly with other people and institutions. Those interactions can pose a real problem to some people.

The practice of medicine today is complex because it has so many business ramifications, aside from the professional responsibilities. Social changes have impacted on medicine, growing out of new attitudes regarding life, rights, and responsibilities. Accountability to fellow man has entered into a different era—a different aura, too.

Solo practice does have fringe benefits. Are they tangible benefits? Is it worth the struggle; is it a struggle? There is a place for all ways of life in our society. Because one lives one way, and another a different way, does not make either wrong or undesirable. To serve one's patients on a one-to-one basis, knowing each person as an individual, and to share their joys, as well as their sorrows, are fringe benefits. Helping families grow, and seeing members of the oncoming generation is exciting. Providing the needs and some of the luxuries of life for your own family by the compensation for your service to other families can offer a necessary personal satisfaction. The intangible benefits are great, too—the love of your patients, the satisfaction of victory over illness, and knowing of the faith that we must have in the entire effort.

The solo practice of medicine will not die. We are not loners. We may seem unrealistic to group practitioners. We get tired; but we refresh ourselves by our works. We live our lives as we desire and thrive on that existence. We shall not be overcome.—M.E.A.

State Department of Health

BOOST FOR HOME CARE

On July 10, 1977 Governor Ray signed House File 597 which appropriates \$1,600,000 to the Iowa State Department of Health to expand public health nursing service or visiting nurse service and homemaker home health aide services to additional elderly Iowans for the fiscal year July 1, 1977 through June 30, 1978.

The legislation sets up a formula for allocation of available funds to all local boards of health (99 county and 11 city): "The department may retain not to exceed one percent of the amount appropriated by this section, to be used to pay the costs of administering this section. The remainder shall be allocated for use in the several counties of the state as follows: (a) One-fourth of the total amount to be allocated shall be divided so that an equal amount is available for use in each county in the state; and (b) Three-fourths of the total amount to be allocated shall be divided so that the share available for use in each county is proportionate to the number of elderly persons living in the state." Based on this formula, the allocations are determined as follows:

Total Appropriation	\$1,600,000
For Administration (1%)	16,000
For Local Use	1,584,000
1/4 for Equal Division Between Counties	396,000
Share for Each County (\div 99)	4,000
Share Per Person 60 and Over (\div 477,392)	2.49

The legislation specifies the local board of health should consult with any agencies which provide either public health nursing service, visit-

ing nurse service, or homemaker home health aide service and should then prepare a proposal for the use of the funds. All Iowa counties except four have public health nursing services and all counties have homemaker home health aide service.

Agencies which receive funds through House File 597 will continue to do cost analysis and use the sliding fee scale as they do now. They will also continue to bill Medicare, Medicaid, and health insurance carriers for cases as appropriate.

It is the intent of the General Assembly that these funds not replace any funds currently being used for these services. The funds are to be used for expansion so that more services are provided.

Many boards of health have submitted proposals for the use of the House File 597 funds and have received approval to proceed. Public health nursing and homemaker home health aide agencies are adding staff with these funds and are able to serve additional patients. Iowa physicians should check with their local agencies about the expansion that is occurring. You are also urged to refer any patients who could benefit from home health services to the appropriate local agency.

This legislation provides the first state funding for local public health services in Iowa. Any general questions regarding this effort which cannot be answered locally should be directed to: Ronald D. Eckoff, M.D., M.P.H., Chief, Division of Community Health, Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319, Telephone 515/281-4910.

HIGH RANKING . . . Iowa ranks fourth in the nation in percent of mothers who begin prenatal care in the first trimester, according to the Na-

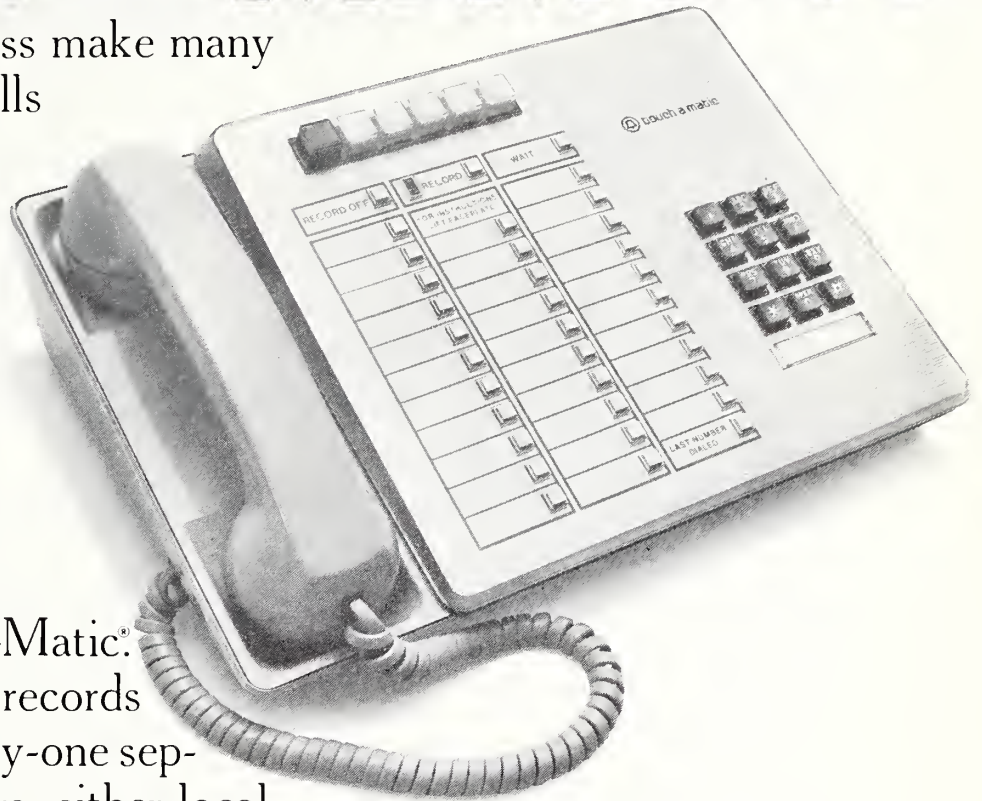
tional Center for Health Statistics. Iowa (with 82%) ranks behind Rhode Island (86.3), Utah (85.7) and Connecticut (85.2).

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Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); and 25 mg phenobarbital in the immediate release layer.

SUSTAINED ACTION

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

See next page for brief summary.



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Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

Tedral SA: each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital in the immediate release layer.

Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral Elixir is convenient for persons who may have difficulty in swallowing tablets.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

Tedral SA: *Adults*—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Children*—Not established for children under 12.

Tedral Elixir: *Note:* One teaspoonful is equivalent to *one-quarter* Tedral tablet. *Children*—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. *Adults*—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

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Full information is available on request.

Morbidity Report for July, 1977

Disease	July 1977	1977 to Date	1976 to Date	Most June Cases Reported From These Counties
Amebiasis	4	71	33	Boone
Chickenpox	9	7362	8966	Black Hawk, Dubuque
Conjunctivitis	33	1747	1476	Jones
Gastrointestinal				
viral infection	69	16259	16262	Black Hawk, Johnson
Giardiasis	7	52	16	Polk
Hepatitis				
A	11	66	86	Scattered
B	11	74	54	Polk
unspecified	2	22	11	Scattered
Impetigo	15	411	485	Black Hawk
Infectious				
Mononucleosis	22	708	676	Johnson
Influenza-like				
illness	56	40436	32946	Black Hawk
Meningitis, aseptic	2	4	10	Johnson
Mumps	5	1258	1191	Black Hawk
Pediculosis	8	234	273	Dubuque
Pinworms	1	30	21	Polk
Pneumonia	20	604	689	Dubuque, Scott
Rabies in animals	8	70	80	Scattered
Ringworm, body	2	185	170	Black Hawk
Rubella	2	160	90	Dubuque, Johnson
Rubeola	26	4261	18	Polk, Black Hawk
Salmonellosis	56	154	68	Keokuk, Dubuque
Scabies	13	596	430	Polk
Shigellosis	1	23	58	Johnson
Streptococcal				
infections	57	8619	10958	Johnson, Mills
Tuberculosis				
total ill	8	62	62	Scattered
bacteria positive	7	50	56	Scattered
Venereal diseases				
Gonorrhea	462	3236	3883	Polk
Syphilis	17	191	198	Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
 Coxsackie B3 isolated—1, Coxsackie B1 isolated, ECHO virus 4—1, Herpes simplex—9, Mycoplasma pneumoniae—1.

CONFERENCE FOR FP RESIDENTS . . . A Conference for Family Practice Residents is planned in Des Moines September 30-October 2. October 1 is designated as the Family Practice Opportunity Fair and will enable representatives of Iowa communities to confer with the FP residents.

About IOWA Physicians

Dr. Thomas Hansen has been appointed clinical director at the Mt. Pleasant Mental Health Institute. Dr. Hansen received the M.D. degree at U. of I. College of Medicine and had his psychiatric residency at Lafayette Clinic in Detroit, Michigan. He has been on the MHI staff since July 1975. . . . **Dr. Floyd Rolfs**, Parkersburg physician for 40 years, retired in June. A graduate of U. of I. College of Medicine, Dr. Rolfs practiced in Brooklyn for one year prior to locating in Parkersburg. . . . **Dr. Frank S. Downs** has joined **Drs. Wayne Rouse** and **John R. Anderson** in Boone. Dr. Downs received the M.D. degree at U. of I. College of Medicine and had a family practice residency at Broadlawns Hospital in Des Moines. . . . **Dr. Dale Trombley, II**, began a family practice in Ida Grove in July. Dr. Trombley recently completed his family practice residency at Oakwood Hospital in Dearborn, Michigan. He comes to Ida Grove under the National Health Service Corps program. . . . **Dr. Joe Wojcik** has joined **Drs. H. O. Stoutland, Donald Boldt**, and **Gary Lawrence** in family practice at the Ackley Medical Center. Dr. Wojcik received the M.D. degree at U. of I. College of Medicine and recently completed his family practice residency at Broadlawns Hospital in Des Moines. . . . **Dr. Robert M. Carney**, Grinnell, has been named county medical examiner by Poweshiek County Board of Supervisors. Dr. Carney succeeds **Dr. Kenneth Caldwell**, who recently left Montezuma to join the Student Health Center at the University of Northern Iowa in Cedar Falls.

Dr. Michael J. Gimbel joined **Drs. William McCabe, Warne Ramsey**, and **Alan Swearingen** in family practice at the Bettendorf Medical Center on August 1. Dr. Gimbel received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at San Bernardino County Medical Center, San Bernardino,

California. . . . **Drs. Dean Dobkin** and **Paul Kauffman** joined the emergency room staff at Keokuk Area Hospital in July. Both received the M.D. degree at Albany Medical College in Albany, New York. Dr. Dobkin interned at Wayne State University in Detroit, Michigan, and Dr. Kauffman at the University of Florida in Gainesville. . . . **Dr. Philip W. Meyer** has joined **Dr. Elmer Bean** to practice pediatrics in Council Bluffs. Dr. Meyer received the M.D. degree at University of Nebraska and took his postgraduate training at Children's Hospital in Philadelphia, Pa. . . . **Dr. Robert W. Linthacum** will close his medical practice in Traer October 1 to join a Des Moines insurance company. Dr. Linthacum moved from Dysart last year to the newly completed North Tama Medical Center in Traer, joining **Drs. Robert Downie** and **Norman Westhoff**. . . . **Dr. Al Healy**, Iowa City, has been appointed to head a new division of developmental disabilities within the Department of Pediatrics at the U. of I. College of Medicine.

Dr. Kenneth Hunziker began a family practice at Spencer Medical Associates in July. Dr. Hunziker received the M.D. degree at U. of I. College of Medicine and had his residency in Cedar Rapids. . . . **Dr. Sushma Sahai** is practicing pediatrics at Medical Associates in Webster City. Dr. Sahai received the M.D. degree at New Delhi University in India and completed her pediatric residency at Blank Children's Hospital in Des Moines. . . . **Dr. Kent A. Rogers** and **Dr. Mark S. Taylor, D.O.**, recently joined the Morningside Mercy Medical Park Center in Sioux City. Dr. Rogers received the M.D. degree at University of Nebraska; interned at Oklahoma's Children Memorial Hospital in Oklahoma City; and served his pediatric residency at the University of Mississippi in Jackson and the Oklahoma Children's Hospital. Dr. Taylor, a family practitioner, received his doctor of osteopathy degree at College

of Osteopathic Medicine and Surgery in Des Moines and took his postgraduate training at St. Michael's Hospital in Milwaukee, Wisconsin. . . . **Dr. Jay Mixdorf**, family practitioner, and **Dr. Dilip Parikh**, surgeon, recently began the private practice of their specialties in Algona. Dr. Mixdorf received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Broadlawns Hospital in Des Moines. Dr. Parikh received the M.D. degree at Baroda Medical College in India; interned at Michael Reese Hospital in Chicago and Wayne State University Hospital in Detroit; and completed his surgical residency at Iowa Methodist Medical Center in Des Moines.

Dr. Percy G. Harris, Cedar Rapids, has been appointed by Governor Robert Ray to a six-year term on the state board of regents. Dr. Harris received the M.D. degree at Howard University; interned at St. Luke's Hospital and opened his family practice in Cedar Rapids in 1958. . . . **Dr. H. Lee Jacobs**, U. of I. College of Medicine professor emeritus, was honored recently at a two-day conference of nursing and retirement home administrators in Iowa City. Dr. Jacobs was presented an engraved plaque recognizing his service in the field of gerontology. . . . **Dr. R. E. Mailliard** and **Dr. R. R. Hansen**, longtime Storm Lake physicians, were honored recently for their 40 or more years of medical service to the community. July 10 was proclaimed, "Drs. Mailliard and Hansen Day," and a reception at Buena Vista College was sponsored by the Buena Vista County Hospital Auxiliary and Buena Vista County Nurses Association. Dr. Mailliard came to Storm Lake in 1934 and Dr. Hansen in 1937. . . . **Dr. Terence Williams**, professor and head of the Department of Anatomy at the U. of I. College of Medicine, recently was awarded a doctor of science degree from the University of Manchester, England. Dr. Williams is a native of England. He received his B.M. degree from the University of Manchester and his Ph.D. in anatomy at the University of Wales, Cardiff, Wales. He has been head of the U. of I. Department of Anatomy since 1973.

Dr. Elias C. Jacobo, urologist, has joined Drs. **Arthur Woodward** and **Richard Long** in Waterloo. Dr. Jacobo received his medical training at University of Mexico in Mexico City and recently completed his residency in urology at U. of I. College of Medicine.

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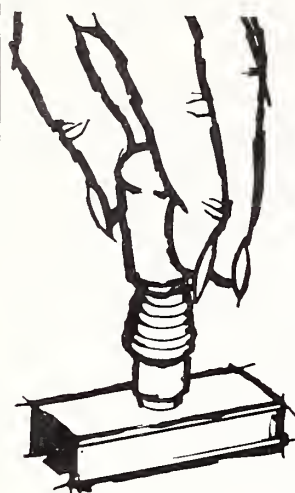
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Dr. Yotin Keonin has joined the McCrary-Rost Clinic in Lake City. A native of Thailand, Dr. Keonin received his medical education in Bangkok; interned at MacNeal Memorial Hospital in Berwyn, Illinois; and served his residency in surgery at VA Hospital in Des Moines. . . . **Dr. Gary Phelps** has opened an ophthalmology practice in Waterloo. Dr. Phelps received the M.D. degree at U. of I. College of Medicine; interned in San Francisco; and completed his residency in ophthalmology at University Hospitals in Iowa City. Dr. Phelps brother, **Dr. Dale Phelps**, is an orthopedic surgeon in Waterloo. . . . **Dr. Harold L. Mihm** is new associate of **Drs. Donald J. Hemming** and **Eugene L. Kerns** in Davenport. Dr. Mihm received the M.D. degree at U. of I. College of Medicine; interned in Johnstown, Pa.; and completed an obstetrics and gynecology residency and one-year fellowship in reproductive endocrinology at University Hospitals in Iowa City. . . . **Dr. William I. Evans**, a radiologist at Grinnell General Hospital since 1968, recently announced his retirement. Dr. Evans received the M.D. degree at U. of I. College of Medicine. Prior to completing his residency in radiology at University Hospitals, Dr. Evans was in family practice.

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Medical Assistants



by BETTY EHLERT, CMA-A

SAN FRANCISCO MEETING

The annual convention of the American Association of Medical Assistants will be October 15-22 at the St. Francis Hotel, San Francisco, with Mrs. Jeanne Green, CMA-A, Davenport, to be installed as AAMA President. California medical assistants will host a "Welcoming Party" October 16 and the House of Delegates will convene October 17.

A major educational speaker will be Elizabeth Kubler-Ross, M.D., lecturer and author of "On Death and Dying" (1969). Dr. Kubler-Ross has devoted her career to the study and treatment of terminal patients and their families. She has visited many countries to learn about the dying process and its effect on the particular culture. Her numerous interviews with patients said to have clinically expired and been revived by exceptional measures confirm what she considers to be life after death. Her book, *Death—The Final Stage of Growth* (1977) has inspired a series of other case-history studies which support her thesis. She is currently at work on a book entitled *Children and Death*.

Georgette McGregor, Ph.D., professor of effective speech and human understanding at the University of California, will address the session. Dr. McGregor is a recognized speech and communication consultant to business, industry and government.

1977 CERTIFICATION EXAMINATION

A record number of candidates (Medical Assistants, Medical Assisting Educators and Students) wrote the 1977 AAMA Certification Examination on June 3 at 104 test centers throughout the United States.

Candidates were to be notified of test results in August and certificates will be presented at the annual CMA Dinner October 19 in San Francisco.

Don Harper Mills, M.D., J.D., clinical professor of Pathology at the University of Southern California School of Medicine, will address an education session on the "Interaction of Medicine and Law."

Workshops and education sessions also include Cardiopulmonary Resuscitation; Effective Listening; Who Do You Think You Are?; Profiles in Urinalysis; The Doctor's Time and How to Schedule It; YOU, The Telephone Manager; Confident Leadership Through Effective Communications; Constitution and Bylaws; and Continuing Education. CEU credits will be offered by AAMA.

The program for medical assistant educators will be October 15-16. Workshop topics will cover Externship; Designing a Competency Curriculum; Techniques of Needs Analysis for Medical Assisting; Individualized Instruction in Administrative Procedures; Methods of Teaching Psychology in Medical Assisting Programs; and Core Curriculum and Simulation Laboratories. CEUs will also be given.

The convention will be followed by a post-convention tour to Hawaii.

SIOUXLAND CHAPTER

Susan Sonnel, assistant trust officer of the Toy National Bank, Sioux City, spoke at a recent meeting of the AAMA, Siouxland Chapter. Her program topic was "Probates, Wills and Estates."

DES MOINES CHAPTER

Mr. Bert Smith, President, Doctors Service Bureau, will present a six-week course on "Credit and Collection Techniques" beginning September 12. For further information on this class, contact Rosemary Herman, CMA-AC, Education Chairman, at 967-5962.

LIST YOUR WANTS

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President's Page

Football teams hear most of the cheers this time of year. And while those who battle on the gridiron deserve them, let me raise a figurative megaphone for a written but rousing cheer to Iowa's physicians.

Active participation by Iowa doctors at the county, state and national levels is my reason for cheering. We are experiencing an extremely good membership year in 1977.

To illustrate, in August, a mailgram was received from James Sammons, M.D., Executive Vice President of the American Medical Association, advising that the IMS was one of eight states to have exceeded its AMA membership level from the preceding year. This point was reached with four months left in the year. Dr. Sammons said "bravo" to Iowa and expressed hope other states would be inspired to do the same. Iowa membership in the AMA this year is 2,166 (as of August 1, 1977) compared with 2,115 at the end of 1976.

Even more impressive is the record of 1977 participation in the Iowa Medical Society. This year (as of August 1) 2,562 physicians (all classes of membership) belonged to the IMS as related to 2,370 at the close of 1976.

We move soon to a new year and membership renewal. Having the privilege of serving now as IMS president, and previously as an Iowa delegate to the national level, I would like to repeat and underscore what has been said many times before: *Full membership and participation are crucial if our profession is to meet the challenges of our time and influence the outcomes.*



L W Swanson M.D.

L. W. Swanson, M.D., President

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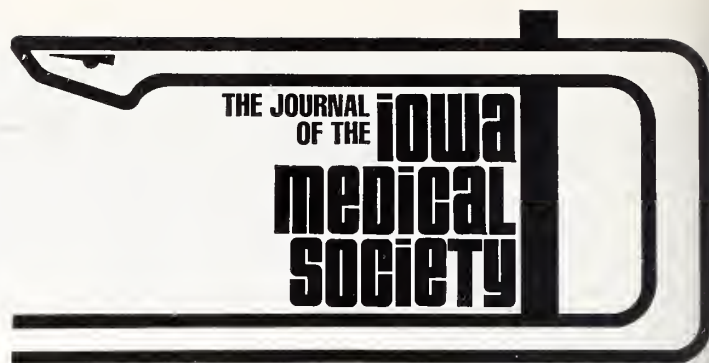
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VOL. 67, No. 10

OCTOBER 1977

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IOWA Medical Miscellany

FALL CONFERENCE . . . October highlight on the IMS schedule is the Fall Leadership Conference. The October 19 session for county society presidents and others will include a presentation by William Mangold, M.D., J.D., vice-chairman of the AMA Council on Legislation. The conference will also include an interesting session on how to increase your effectiveness as a speaker. All counties have been urged to have a representative present.

BOARD OF HEALTH . . . F. M. Ashler, M.D., Hamburg, has been named to a three-year term on the Iowa State Board of Health. Dr. Ashler is a past-president of the Iowa Academy of Family Physicians.

OTHER APPOINTMENTS . . . Don E. Boyle, M.D., Sioux City, has been appointed to the Governor's Emergency Medical Services Advisory Council. Kirk E. Strong, M.D., Fairfield, has been named to the 9-member Iowa Commission on Substance Abuse. This latter commission will serve the new State Department of Substance Abuse which is to become active January 1, 1978.

IMMUNIZATION SEMINAR . . . Aspects of the new Iowa immunization law will be reviewed for interested physicians and/or their employees in a November 16 conference at IMS Headquarters. The meeting is a joint project of the IMS Committee on Maternal and Child Health and the Iowa State Department of Health.

INDUSTRIAL INJURY SEMINAR . . . Open to all interested physicians will be a November 4 Industrial Injury Seminar at the Des Moines Hilton Inn. The program will center on back injuries and will be presented by the Industrial Injury Clinic of the Theda Clark Memorial Hospital in Neenah, Wisconsin. It is a project of the Iowa Workers' Compensation Advisory Committee. More info is available from IMS Headquarters.

ROSTER MAILED . . . The 1977-78 Iowa Medical Society Membership Roster was mailed last month to all member physicians. The Roster contains alphabetic and geographic (by county) listings of Society members, along with listings of IMS officers, committee members, frequently called telephone numbers, etc.

CALENDAR OF EVENTS . . . Also mailed to IMS members in September was a 1977-78 Calendar of Events which provides the dates of those major events which are known at this time.

IMS/AETNA PROGRAM PROGRESSING . . . Pushing beyond the 600 level in number of IMS members participating, the IMS/Aetna Liability Insurance Program continues to draw inquiries from (a) new physicians, (b) physicians desiring hard-to-obtain excess limits of coverage, and (c) physicians apprehensive over the claims-made form. New Aetna account supervisor Darrell Chapman is at work in Des Moines. Info on the program is available from IMS Headquarters.

BME INVITES . . . The Board of Medical Examiners is inviting the IMS and the Iowa Society of Osteopathic Physicians and Surgeons to designate (probably three from each) member physicians to confer in the next few weeks regarding the new Iowa law which requires the Board to implement continuing education and disciplinary measures.

IMS CITED . . . The Iowa Medical Society was cited in September for achieving a 1977 membership level in the American Medical Association which surpasses the year-end total for 1976. AMA membership (including life and associate members) was 2,166 as of July 31; it was 2,115 for the entire year of 1976. Full membership in the IMS as of August 1 was 2,562, compared with 2,370 at the end of 1976.

(Please turn to page 397)

Joining together is a natural pattern

When goals are common, joining together is natural. That's why the Iowa Medical Society is the best place for members to join together for their Professional Liability Insurance. The Iowa Medical Society is sponsoring a valuable program of malpractice coverage designed by Aetna Life & Casualty for your needs.

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LIABILITY PROGRESS MADE IN IOWA THIS YEAR

A CRUCIAL SEARCH for answers to the problems associated with medical liability (malpractice) insurance began in earnest three or so years ago. A near-crisis was at hand for some Iowa physicians at that time. This insurance coverage was virtually non-existent in certain medical specialty areas. And when it was available the premiums were often out of sight. It was an exasperating interval.

Please be assured the liability dilemma has not disappeared. It has abated somewhat however. Several important actions—by the Iowa General Assembly, by the Iowa Medical Society, by the Insurance Commissioner, by the insurance industry—have helped improve the situation. But certainly the task of identifying and implementing equitable remedial measures must go on.

This year of 1977 has been one of progress. Several positive steps have been taken to further diagnose and treat the malpractice problem. The activity has involved both the private and public sectors. *What has happened?*

- **The Iowa House of Representatives passed House File 179 on April 6!** This legislation contains several provisions (e.g., periodic payment of large judgments, voluntary use of binding arbitration) which are believed to be worthy of enactment into law. This bill remains active for consideration by the Iowa Senate when the General Assembly reconvenes in January. It is appropriate legislation to follow the 1975 passage of House File 803 (with its several tort reforms).

- **The Iowa Medical Society joined with Aetna Life and Casualty to offer a liability insurance program to member physicians.** The official inauguration of this program was on March 15. Its adoption came after considerable study and represents an action of major consequence.

In six months since the IMS/Aetna program became operational, over 600 Iowa physicians have enrolled. This is good progress in view of a restored competitive market. The IMS/Aetna program is comprehensive in nature, providing basic professional, office premises and excess limits

coverage for liability exposures. It is the traditional occurrence type of insurance which means the insured physician is covered for the acts he/she performs in the coverage year (1977) regardless of when any claim is filed (1979, 1981, etc.).

Those physicians who studied the IMS/Aetna proposal prior to its adoption viewed it as a tangible response to the problem by the medical profession. They see it as a way of directly involving the medical profession with a major insurance company to try to structure and maintain a viable program. Work is now underway to establish claims review mechanisms which will facilitate and assure the fair handling of any actions brought against those insured under the program.

The IMS/Aetna program is a new and important option intended to serve Iowa physicians directly and the public indirectly.

- **The Iowa Hospital Association, through its affiliate Iowa Hospital Educational Research Foundation, has received a three-year \$598,054 grant from the W. K. Kellogg Foundation to undertake a significant Risk Management Program.** Official beginning of this program was August 1.

As the title suggests, this project will seek to discover where the greatest inpatient medical care risks are, and will then blueprint ways of curtailing these risks. Data submitted by participating hospitals will be computerized and evaluated. From this is expected to come injury prevention programming intended to maximize quality and safety in the delivery of inpatient services.

This praiseworthy project of the Iowa Hospital Association was supported in its proposal stage by the Iowa Medical Society. And it will continue to receive requested medical input via participation by the IMS on an advisory council which is being formed.

Described only briefly here, these several 1977 activities illustrate the effort being made to improve the health care liability picture. This complex subject area will demand ongoing attention for some time.

IN THE PUBLIC INTEREST

The Question Box



by MRS. J. L. KEHOE

Kay Kehoe is president of the Iowa Medical Society Auxiliary. Her husband is a pediatrician in Davenport.

How do you describe the purposes of the Auxiliary?

As stated in our by-laws, the primary purpose of the IMS Auxiliary is *to assist the Society in the advancement of medicine and public health*. Our involvement in community medical efforts has proliferated since the Auxiliary was organized 50 years ago. Today our members ask what they can do about attacks on medical practice, and how they can protect the best system of health care the world has known. Because we care, a past IMS president has called us "medicine's other hand."

A second purpose is *to coordinate and advise in the activities of county auxiliaries*. Our most important work is done at the community level; the state organization is the vehicle through which the AMA Auxiliary speaks to the membership. Our state officers and committee chairmen are trained to offer the counties and members-at-large a variety of aids for local application. National's newest information resource is Project Bank. This is a system where project information is deposited and distributed on request. Subject categories include aging, alcohol, blood, children and youth, health careers, manpower, international health, nutrition, etc.

The third goal is *to cultivate friendly relations and promote mutual understanding among physicians' families*. Medical auxiliaries provide the new doctor's wife a chance to form new and lasting friendships. This bond is most useful as a basis for reaching out into the community to share resources and demonstrate concern.

Beyond those goals, what does the Auxiliary do?

Recruiting and retaining members is paramount. We aim to involve more spouses in health organizations that aspire to improve the quality of life. Our main focus this year is on CPR, child abuse, immunization, and better health education in Iowa schools. We encourage support of AMA-ERF and IMPAC-AMPAC. We inform members on medical legislation, advocate participation in the political system and conduct such activities as a legislative wives' brunch. A Planning Committee meets regularly to assess our programs and determine future directions.

Will the Auxiliary have anything new this year?

Last Spring the IMS encouraged us to schedule a Public Affairs Workshop. This will attempt to present some of the new "medical facts of life." It will be October 27 in Des Moines between 10 a.m. and 3 p.m. We are calling it, *A WAY TO GROW: What We Need to Know (And Don't Know Who to Ask)*! We hope to cover NHI, professional liability, HSA, Community Involvement, Legislative Contact, etc. Excellent speakers are scheduled and it should be a great learning opportunity for all wives of Iowa doctors.

Should IMS member physicians encourage their spouses to be active in the Auxiliary?

Why would they not? Considering the "big guns" leveled at medicine, the profession needs all possible allies. Dedicated and inspired women with a variety of skills are blending talents all over the country—to make a difference. We can do more to help the medical cause **TOGETHER** than any one of us can do alone!

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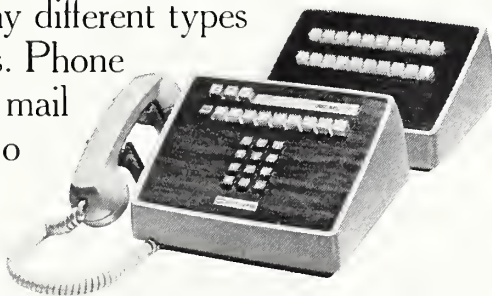
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Educationally Speaking

by R. M. CAPLAN, M.D.

"... TOO MUCH OF A PRACTITIONER"

Sometimes I hear criticism of physicians, often from other physicians, for being so busy from the pressures of their practices that they fail to do what's necessary to "keep up." I can appreciate that dilemma. Few individuals can turn to tasks of mental challenge after a long day of pressured work, and especially when there are affairs of family, civic life, recreation and rest still to be attended to. Yet there are individuals who work 12-hour days, respond to needs of family and community and still manage to have motivation and energy enough to work at their own professional refurbishing.

Is there a "mind set" that makes the difference? Does there exist a subtle *self-identification as a student* which persists in some of us and prompts continued effort at learning . . . while others feel they lay down the mantle of student and pick up the mantle of practitioner. Perhaps the distinction needn't be "either-or," and the distinction certainly isn't a new one. For example, in 1801 when Beethoven was aware of increasing trouble with his acoustic apparatus, he suffered much anguish. His letters to friends gave glimpses of his stress and annoyance at buzzing sounds

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

and impaired hearing, and even more of the psychological torment of a genius whose meaningful life and immense talent were threatened by the progression of his deafness. He obviously sought help from medical practitioners as well as from almost anyone else, and of course obtained no real help anywhere. In one of his distressed letters to a friend in 1801 he complained, ". . . It seems to me that Vering is too much of a practitioner to be able to take in new ideas through books."

The phrase "too much of a practitioner" intrigues me. I suspect the great composer felt that Dr. Vering was not simply too busy, but rather, that he was of a certain frame of mind, a disposition, a temperament that had moved him from the category called "student" to the category called "practitioner" with no prospect for the former to reappear and contaminate the latter. I think we may conclude also that Beethoven valued Dr. Vering less highly for his disinclination "to take in new ideas through books."

Whatever it is that creativity represents, it always seems to have associated with it a receptivity for ideas, a satisfaction from absorbing and synthesizing new perspectives. If a physician is to be a creative clinical problem solver rather than a mechanical "fixer," then we will expect to see evidence of his willingness to consider new ideas—not just willingness, but even more, an active seeking for new ideas.

MEDICAL GENETICS MEETING

A program for Iowa physicians on Medical Genetics will occur November 2 in Ames at the Iowa State University Scheman Continuing Education Center.

The program is part of the Regional Genetic Consultation Services which is affiliated with the State Department of Health Birth Defects Insti-

tute. Hans Zellweger, M.D., pediatrician and geneticist at the U. of I. Department of Pediatrics, is the RGCS clinical director. The Ames course will cover (1) genetic and environmental factors in birth defects; (2) prenatal genetics; (3) patient referral information, and (4) genetics of diabetes.

CME credit will be available. More info is available from Dr. Zellweger (319/356-2674).



SCIENTIFIC ARTICLES

Malignant Gestational Trophoblastic Disease

SAMUEL LIFSHITZ, M.D.,
CHRISTOPHER OUTHOUSE, M.S., and
HERBERT J. BUCHSBAUM, M.D.

Iowa City

GESTATIONAL TROPHOBLASTIC DISEASE represents a spectrum of neoplasia from benign to highly malignant. These tumors arise from the placenta and are unique insofar as they are genetically different from maternal tissues and characteristically produce human chorionic gonadotropin (hCG). For these reasons, gestational trophoblastic tumors have assumed great importance in the study of cancer therapy, autoimmune diseases and organ transplantation.

In the last two decades significant progress has been made in the treatment of malignant gestational trophoblastic disease. Chemotherapy now provides high cure rates, with preservation of reproductive function. Despite such advances, women still die of placental malignancies because of late diagnosis and inappropriate therapy. In an 11 year period, January 1, 1966 to December 31, 1976, 51 patients with gestational trophoblastic disease were seen in the Department of

Dr. Lifshitz is an assistant professor in the Department of Obstetrics and Gynecology, University of Iowa College of Medicine. Mr. Outhouse is a senior medical student in the U. of I. College of Medicine. Dr. Buchsbaum is a professor in the U. of I. Department of Obstetrics and Gynecology.

Early diagnosis of trophoblastic disease has brought high cure rates. Virtually all patients can be successfully treated with drugs and techniques now available. Described here are 51 patients seen over an 11-year period at the University of Iowa.

Obstetrics and Gynecology, University of Iowa Hospitals, and are the basis of this report. Current thoughts on diagnosis, treatment and follow-up of patients with trophoblastic disease are discussed.

HISTOPATHOLOGY

In hydatidiform mole the placental villi are hydropic and edematous; there is loss of the vasculature and varying degrees of trophoblastic proliferation. The neoplasm may remain intrauterine, may invade the uterine musculature or other pelvic structures and cause morbidity from uterine perforation, hemorrhage and sepsis.

Choriocarcinoma is characterized by malignant sheets of syncytial and cytotrophoblastic cells, with associated hemorrhage and necrosis. Chorionic villi are typically absent. It is a highly malignant tumor with predisposition to early hematogenous spread. The most commonly involved organs in decreasing order are lungs, lower genital tract, brain, liver and kidneys (Figure 1).

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS
THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF OCTOBER 1977.



Figure 1.* Chest X-ray demonstrating diffuse bilateral lung metastases from gestational choriocarcinoma.



Figure 2.* Surgical specimen showing hydatidiform mole in uterine cavity and bilateral theca-lutein cysts.

The histologic characteristics of trophoblastic disease do not correlate well with biological behavior. Dissemination may occur as any of the histological types. For this reason, a therapeutic, clinical and morphological classification has been adopted by the Committee of the International Union Against Cancer that can accommodate all forms of gestational trophoblastic disease (Table I). The classification is simple, and allows comparison of data between different institutions. Of the 51 patients with trophoblastic disease seen at the University of Iowa Hospitals, 44 had non-metastatic and 7 metastatic trophoblastic disease (Table II).

INCIDENCE

The incidence of hydatidiform mole, the most common form of gestational trophoblastic disease, varies widely in the world. The highest inci-

* Figs. 1, 2, 4: From Buchsbaum, H. J., and Chapler, F. K.: Gynecology. In Liechty, R. D., and Soper, R. T.: Synopsis of Surgery, ed. 3, St. Louis, 1976, The C. V. Mosby Co.

TABLE I
CLASSIFICATION OF
GESTATIONAL TROPHOBLASTIC NEOPLASM
(UICC, 1967)

<i>Clinical Diagnosis</i>	<i>Morphological Diagnosis</i>
1. Non-metastatic	1. Hydatidiform mole
2. Metastatic	a. Non-invasive
a. Local (pelvic)	b. Invasive
b. Extra-pelvic	2. Choriocarcinoma
	3. Uncertain

dence is in the Far East (1:135 pregnancies), while it is 1:2000 pregnancies in the United States. Approximately 80% of hydatidiform moles will follow a benign course after uterine evacuation. Twenty per cent of patients will develop malignant trophoblastic disease with either local or metastatic spread.

Choriocarcinoma, the rarest form of gestational trophoblastic disease, occurs in about 1 in 50,000 to 100,000 pregnancies. It is preceded by hydatidiform mole in 50% of the cases. In the others the antecedent pregnancies are evenly divided between abortions, including ectopic pregnancies and normal pregnancies.

CLINICAL

Hydatidiform mole is more common in the extremes of the reproductive life. Of the 51 patients seen at the University of Iowa, 14 were below age 19 and 2 over 40, with a median age of 34 years. There appears to be no correlation between parity and incidence of molar pregnancies. Although the chance for a recurrent mole in a subsequent pregnancy is about 2%, none of our patients have had a recurrent molar pregnancy. The diagnosis of hydatidiform mole is established in only 50% of cases before expulsion of the typical grape-like vesicals. Clinical signs appear most commonly between the 10th and 13th week of pregnancy. Vaginal bleeding is present in almost all cases; it occurred in over 90% of

TABLE II
GESTATIONAL TROPHOBLASTIC DISEASE
UNIVERSITY OF IOWA
JANUARY 1, 1966 TO DECEMBER 31, 1976

Spontaneous remission (no therapy)	16
Patients requiring therapy	35
Non-metastatic	28
Metastatic	7
TOTAL PATIENTS	51

our patients and persisted for several weeks. About half of the patients complained of abdominal pain, and one-fourth of hyperemesis. On physical examination over 30% of the patients had a uterus larger than anticipated by gestational age (Table III). The diagnosis of hydatidiform mole should be suspected in the absence of fetal heart tones or the finding of pregnancy toxemia before 24 weeks gestation. The presence of unilateral or bilateral ovarian theca-lutein cysts resulting from high levels of circulating hCG occurs in about 20% of the patients and reinforces the suspicion of hydatidiform mole (Figure 2).

Human chorionic gonadotropin titers in the urine greater than 500,000 IU/24 hr. is strong evidence of hydatidiform mole. Amniography or pelvic arteriography are invasive diagnostic techniques, technically difficult to perform and hazardous. In amniography, 20 to 30 ml of diatrizoate (Hypaque) are introduced into the uterine cavity transabdominally and abdominal roentgenograms taken. A honeycomb pattern is diagnostic of molar pregnancy (Figure 3). Abdominal ultrasound is currently the most accurate and safe technique for the diagnosis of hydatidiform mole (Figure 4). The accuracy approaches 99% and presents no hazard to mother or fetus.

If the diagnosis of hydatidiform mole is not made until the patient has spontaneously aborted the mole, pitocin infusion, followed by a sharp curettage, is the treatment of choice. In the absence of labor, uterine evacuation should be carried out without delay. Suction curettage is the preferred method of evacuation and can be accomplished in uterus over 12 weeks size with minimal risk. In these cases sharp curettage should be performed after the suction D & C when the uterus has decreased in size. Termination of a molar pregnancy by primary hysterectomy is a reasonable option in the management



Figure 3. Amniogram following transabdominal injection of diatrizoate showing the classic honeycomb appearance of hydatidiform mole (arrow). Uterine size is 34 weeks (thin arrows).

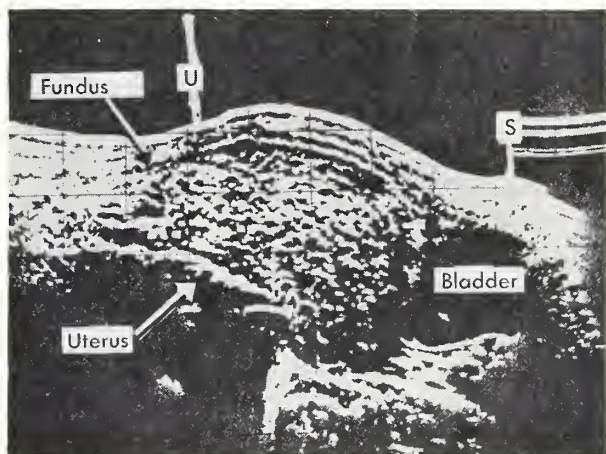


Figure 4.* Longitudinal midline ultrasound scan of abdomen showing diffuse homogenous echoes characteristic of hydatidiform mole. Note absence of fetal parts. (U, umbilicus; S, symphysis.)

of patients who are good surgical risks and who desire sterilization. Thirty-eight of 43 patients seen with molar pregnancies had suction D & C, and 5 underwent primary hysterectomy.

FOLLOWUP

Regardless of the histologic appearance, all trophoblastic tumors secrete human chorionic gonadotropin (hCG) as well as other hormones produced by the normal placenta. The amount of hCG produced closely approximates the amount of viable trophoblastic tissue in the patient.

TABLE III

SIGNS AND SYMPTOMS IN 51 PATIENTS
WITH GESTATIONAL TROPHOBLASTIC DISEASE

Signs and Symptoms	Patients	%
Vaginal bleeding	48	94
Abdominal pain	23	45
Excessive uterine size	17	33
Nausea, vomiting	12	23
Preclampsia	5	10
Hyperthyroidism	2	4

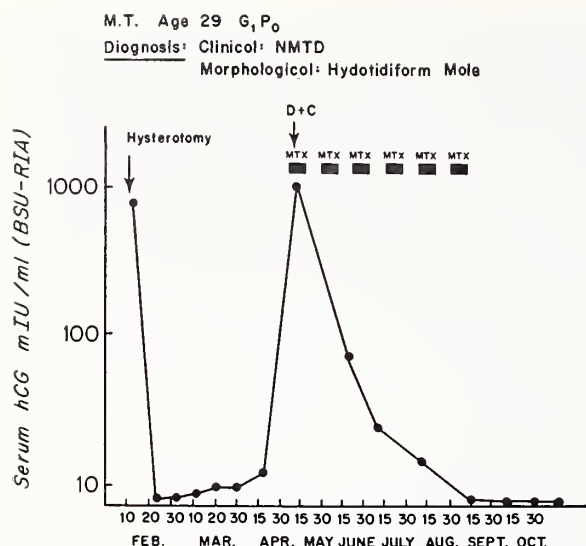


Figure 5. Graph showing hCG titers in patient with non-metastatic trophoblastic disease (NMTD) in complete remission since September 1976, following 6 courses of Methotrexate. Blackened areas indicate 5 day course of chemotherapy.

The routine immunologic and biologic tests are of limited use in following patients with trophoblastic disease. These tests give a positive result when 1000 IU hCG or more are present, and are not sensitive enough to follow patients with low titers. In fact, 30% of patients with trophoblastic disease will have hCG titers below 1000 IU.¹ Prior to 1972, nonspecific radio-immunoassay techniques were used to measure hCG. The difficulty encountered became apparent when the hCG titers dropped to the range of endogenous pituitary luteinizing hormone levels with which hCG cross-reacts; when that happened it was assumed that all trophoblastic tissue was eradicated. Recurrent disease occurs in about 10% of patients whose titer drops below 1000 IU.

The specificity of hCG radio-immunoassay has been enhanced by means of measuring the beta subunit of hCG.² This specific assay permits the measurement of minute amounts of hCG in the presence of LH and has provided the ideal tool for followup and management of patients with trophoblastic disease.

Following evacuation of a mole, the hCG titers should be measured weekly or biweekly to be sure the level is falling. Most titers regress to normal in 12 weeks. If the titer plateaus or increases, one should suspect malignant disease. In our series, 16 patients followed a benign course after uterine evacuation and 35 developed malignant disease requiring therapy (Table II).

Ideally hCG titers should be determined by the most sensitive and specific method available. With the more specific beta subunit radioimmunoassay, complete disappearance of hCG occurs at an average of 90 days following evacuation of a molar pregnancy by suction D & C and 55 days following abdominal hysterectomy.³ This discrepancy probably reflects more complete removal of the trophoblastic cell mass by hysterectomy. When less sensitive assay methods are used, hCG levels below 5 mIU/ml overlap with physiological levels of LH, giving a false impression that all viable trophoblastic tissue is eradicated. In most instances, when the hCG titer drops to this lower level, remission has occurred. Occasionally, however, hCG titers become elevated and treatment is required (Figure 5). For this reason, a single titer in the normal range, regardless of the assay method used, cannot be relied on as an infallible indication of remission. To avoid this problem, we recommend the program outlined in Table IV for monitoring patients after the evacuation of hydatidiform mole.

The patient is considered to be in remission when three consecutive weekly hCG determinations are normal. It is important to prevent pregnancy during the post-molar followup, since normal pregnancy will elevate hCG. Oral contraceptives are recommended, since they not only prevent pregnancy but also suppress the midcycle LH peak.

Some authors have suggested the use of prophylactic chemotherapy for the management of all molar pregnancies. There are questions regarding the wisdom and safety of administering cytotoxic agents to all patients, since over 80% of the cases follow a benign course after uterine evacuation. Prophylactic chemotherapy has not been used at the University of Iowa. Its use does not completely prevent persistent trophoblastic disease, and the cure rate for those few who develop localized malignant disease is almost 100%

TABLE IV
 POST-MOLE SURVEILLANCE PROTOCOL

1. Quantitative hCG determinations.
 - a. Weekly until 3 consecutive normal values obtained.
 - b. Monthly \times 6 months.
 - c. Every 2 months \times 6 months.
2. Oral contraception \times 12 months.
3. Chest X-ray.
4. Pelvic examination every 2 weeks until hCG normal, then every 2 months \times 6 months.

TABLE V
POOR PROGNOSIS METASTATIC
TROPHOBLASTIC DISEASE

1. Metastatic disease with hCG excretion $> 100,000$ IU/24 hours.
2. Metastatic disease with > 4 months duration.
3. Brain or liver metastasis (regardless of duration or hCG level).
4. Metastatic disease resistant to single agent chemotherapy.

when adequate treatment is given.

TREATMENT

Indications for treatment include a plateau or rising hCG titer, the presence of metastases, or tissue diagnosis of choriocarcinoma or invasive mole.

It is no longer appropriate to initiate treatment of patients whose hCG levels are still elevated after 60 days with a continued drop in titers. With more sensitive and specific hCG assays, patients are encountered who require 90 days or longer to complete regression of the hCG level. The pattern of hCG regression is more important than the actual time it takes for regression to occur. Should repeat sharp curettage be needed, it should be performed on the second or third day of the first course of chemotherapy.

Systemic chemotherapy has provided a major breakthrough in the treatment of trophoblastic disease. Methotrexate and Actinomycin-D used singly in 5-day courses repeated every 2 or 3 weeks have demonstrated clearcut superiority to all other cytotoxic agents in the treatment of this disease. Nearly 100% cure rates have been obtained in patients with nonmetastatic, and 85% in patients with metastatic disease.⁴ All 35 patients treated with chemotherapy in our series are in complete remission for a cure rate of 100%. In contrast, two patients seen, who received chemotherapy elsewhere, died. The first had chemotherapy-induced bone marrow depression, developed overwhelming sepsis, and expired shortly after admission to University Hospitals. The second patient had metastatic disease to the brain and liver, developed brain hemorrhage, and expired a few hours after admission.

Patients in the poor prognosis category (Table V) should be treated with combined administration of 3 agents, Methotrexate, Actinomycin-D, and Cyclophosphamide, in 5-day courses every 3 weeks, provided all clinical and laboratory evidence of toxicity is resolved. With close clinical and laboratory monitoring, proper-

TABLE VI
ROLE OF HYSTERECTOMY IN THE MANAGEMENT
OF GESTATIONAL TROPHOBLASTIC DISEASE

1. Primary management of hydatidiform mole—good surgical candidate who requests sterilization.
2. Management of nonmetastatic trophoblastic disease—good surgical candidate who requests sterilization.
3. Management of uterine disease resistant to chemotherapy.

ly timed change of drug or dosage, and attentive supportive care, a 75 to 80% cure rate can be anticipated in poor risk patients.⁴

In selected patients with metastases, the use of adjunctive radiotherapy delivering 2000 rads to brain or liver metastases frequently allows for completion of chemotherapy without major hemorrhage from metastatic foci. Intra-arterial infusion chemotherapy to liver or uterus is often effective in eradicating persistent disease in these organs.

The role of hysterectomy in the treatment of trophoblastic disease has varied over the years. In the pre-chemotherapy era, early hysterectomy was used in patients with nonmetastatic disease. The advent of effective chemotherapy has changed the role of hysterectomy in the treatment of trophoblastic tumors. The indications for hysterectomy in the management of gestational trophoblastic disease are shown in Table VI.

Patients with malignant gestational trophoblastic disease are best treated at medical centers where sensitive hCG assays and specialized diagnostic and therapeutic procedures are available. The physician treating malignant trophoblastic disease must be familiar with the drugs and their side effects.

Like any other malignant process, early diagnosis of trophoblastic disease is associated with limited disease and high cure rates. A high index of suspicion and the frequent use of sensitive hCG assays are aids in diagnosis. Essentially all patients with malignant trophoblastic disease can be successfully treated with drugs and techniques currently available.

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A Possible Case of Mucocutaneous Lymph Node Syndrome in Iowa

S. C. GLEASON, D.O., and

R. W. OVERTON, M.D.

Des Moines

An unusual case is described. The five-year-old patient presented negative laboratory data for the common infectious diseases. The concluding hypothesis following study by public health officials was mucocutaneous lymph node syndrome.

MUCOCUTANEOUS LYMPH NODE SYNDROME (MLNS) is a newly recognized entity first described in Japan.^{1, 2} Principal symptoms include fever, conjunctivitis, oral mucosal erythema, generalized or localized rash involving the palmar and plantar surfaces and generalized adenopathy. All laboratory data for other infectious diseases is uniformly negative. Diseases included in the differential diagnosis are scarlet fever, Stevens-Johnson Syndrome, infantile periarteritis nodosa, as well as a myriad of other infectious processes such as leptospirosis, brucellosis, rickettsial diseases, etc.

Many times MLNS is accompanied by carditis, arthritis, hepatitis and mild renal abnormalities. A possible case is summarized below and was reported statistically in the Morbidity and Mortality Weekly Report of the CDC on May 28, 1976.²

CASE HISTORY

A five-year-old white female was admitted November 21, 1976. The mother stated the child had high fever, chills, confusion, painful muscles and joints during the previous 24 hours. During the preceding two weeks the child was treated on an out-patient basis for fever, diarrhea, generalized adenopathy and pharyngitis. During that period the child had a 26,200 WBC and a positive "mono test" (later found to be false positive). Following a throat culture, oral penicillin was prescribed.

At the time of admission the patient was lethargic with a temperature of 104F. She had gen-

eralized adenopathy, pharyngitis, a morbilliform rash about the trunk, as well as a perioral and palmar desquamating rash. There was a distinct absence of neurological and cardiac abnormalities.

Within two weeks the patient additionally developed conjunctival hemorrhage, arthralgia and myalgia. As the child became more toxic, evidence of pneumonitis, myocarditis, hemolytic anemia and idiopathic hepatitis developed. The patient had elevated bilirubin levels and markedly elevated liver enzymes. Blood cultures for bacteria (including leptospirosis) were negative, as were acute and convalescent serologic studies for leptospirosis, brucellosis, typhoid, rickettsial diseases and tularemia. Repeat "mono spot" and heterophil agglutination tests were negative. Acute and convalescent viral titers were negative. The patient's ammonia and glucose levels remained normal throughout hospitalization. Investigation for underlying autoimmune or malignant process yielded negative results.

The hemoglobin dropped from 15.6 mg% to a low of 8.1 mg%. A transfusion was given and her mental status showed moderate improvement. All antibiotic therapy was stopped.

During the patient's approximate one month of hospitalization the following complications developed:

- 1) Qualitative platelet disorder with normal coagulation profile.
- 2) Idiopathic hepatitis—improved at time of discharge.

Drs. Gleason and Overton are in the private practice of family medicine in Des Moines, Iowa.

3) Mucocutaneous symptomatology—cleared at time of discharge.

4) Idiopathic nephritis with nephrosis—improved at time of discharge.

5) Hemolytic anemia, etiology unknown.

6) Myocarditis—moderately improved at time of discharge.

At the time of discharge the patient was afebrile and responding well to conservative symptomatic therapy. The evidence of myocarditis re-

mained the primary concern. A case summary review was done by several public health personnel with a probable diagnosis of MLNS suggested.

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MEDICAL MISCELLANY

(Continued from page 385)

RADIATION MATTER . . . The appearance of thyroid cancer among individuals who received radiation treatment in the 1930's, 40's and 50's for benign conditions has received notoriety this year. In light of this increased incidence—and the potential risk to others—Iowa physicians are encouraged to notify patients whose records indicate they may have been exposed to this type of treatment. The Society has an informational sheet entitled "Proposed Protocols for Management of Patients Exposed to Head and Neck Radiation for Benign Conditions." This is available on request.

REPRESENTS IMS . . . Clarence H. Denser, Jr., M.D., Des Moines, will represent the IMS on the advisory council being formed by the Iowa Hospital Association to assist with the Risk Management Program which has been funded by the Kellogg Foundation with a grant in excess of \$550,000. The goal of the program is to prevent injuries and to assure greater quality of patient care services in Iowa hospitals.

NEW PROUTY STAFFER . . . The Prouty Company, insurance administrator for the IMS, has added Howard F. Hogan, C.L.U., to its staff. Mr. Hogan is a U. of I. graduate with 25 years of experience in the insurance business. He will be available to counsel with Society members on insurance matters.

IMS APPOINTS . . . Tim Gibson, 25, recent recipient of a master's degree in public affairs at the University of Iowa, has joined the IMS administrative staff. Gibson will undertake various governmental liaison responsibilities and assist with the Society's legislative relations program.

FALL MEETINGS . . . Patient referral procedures followed by University of Iowa Hospitals and Clinics are being reviewed by Iowa physicians and their staff personnel in a series of 11 regional meetings this Fall. The sessions are being arranged by University Hospitals' administrative officials to provide information on appointment-referral protocols and to solicit suggestions. Meeting sites are Burlington, Council Bluffs, Cedar Rapids-Iowa City, Davenport, Des Moines, Dubuque, Ft. Dodge, Mason City, Ottumwa, Sioux City and Waterloo.

RAPE EDUCATION PROGRAM . . . A State-wide Education Program of the Polk County Rape/Sexual Assault Care Center is now operative. Community organizations and agencies—such as hospital medical and nursing staffs, county medical societies—may request in-service education programming. Funds from the Iowa Crime Commission support the project which has a 7-member advisory board. Truce Ordonez, M.D., represents the IMS on the advisory board.

OPHTHALMOLOGY . . . IMS representatives met September 23 with the Iowa Academy of Ophthalmology to review legislation being advocated by the optometrists to expand their practice act to allow for the use of topical diagnostic agents. Earlier in the month officials of the IMS and IAO conferred with representatives of the Iowa Optometric Association.

MEDICAL STUDENT PLAUDITS . . . Karen Weihs and David Loxterkamp, U. of I. medical students, have been elected to the Board of Trustees of the American Medical Student Association. In addition, *Vital Signs*, the U. of I. medical student newspaper, has been named by the AMSA as the outstanding student publication in the country.

Pediatric Nurse Practitioners: Survey of Role and Employment in Iowa

BRENDA M. CRUIKSHANK, M.D.,
JEAN A. LAKIN, R.N., M.P.H., and
CHERYLL M. JONES, R.N., B.S.
Iowa City

PNP's are performing a variety of tasks in different work settings, according to this survey report. The employers—including physicians—describe the work relationship favorably.

A PEDIATRIC NURSE PRACTITIONER (PNP) is a registered nurse who has taken additional training in child health and can function in an expanded nursing role in a physician's office or clinic setting. The PNP may work under direct supervision of a physician or by physician-established protocols which define patient care and responsibilities. She is involved in various child health care tasks which may include: taking medical histories, conducting physical assessments, giving immunizations, assessing speech, hearing, vision and development, obtaining laboratory examinations (hemoglobin, PKU, urinalysis). Her assignments may include nutritional counseling, management of common health problems, newborn care or parental guidance.

PNP TRAINING IN IOWA

The PNP program at the University of Iowa was developed under the guidance of the College of Nursing and the College of Medicine (Department of Pediatrics) in 1972. The primary faculty of the program includes two members of the College of Nursing and one member of the College of Medicine. The training course is 16 weeks long and leads to a PNP certificate and university

credit. An average of eight students have taken the course each semester. During the first three years of the program, with the exception of students concurrently enrolled in the Master's program *Nursing of Children*, applicants were required to have employment where their PNP preparation could be implemented. The program was revised in the fall of 1975, and students are no longer required to have employment as part of the admission criteria. The program is funded by the Board of Regents.

EVALUATION OF PNP GRADUATES

Because the idea of the PNP is relatively new, it is particularly important that the graduates be studied to determine both the adequacy of the training program and their role in providing child

TABLE I
TYPE AND NUMBER OF PNP STUDENTS

College of nursing faculty	3
Nurses employed in health care settings	
Private sector	5
Public health	10
Other (school, neighborhood health center, Iowa State Health Department)	5
Graduate students	21
Total	44

(Continued on page 400)

Dr. Cruikshank is an assistant professor in the Department of Pediatrics at the University of Iowa College of Medicine. Ms. Lakin is an assistant professor in the U. of I. College of Nursing and Ms. Jones is an assistant-in-instruction in the College of Nursing.

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
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health care. To conduct this study, a questionnaire was distributed to 44 graduates, of whom 27, or 61 per cent returned the questionnaire. At the time of admission the students included in this study were employed in the areas indicated below. (See Table I.)

The survey, conducted in January 1975, included a study of the employment of graduates after completion of the program. The sites of employment were essentially unchanged with graduates functioning in a variety of health settings, public health agencies, physicians' offices and schools of nursing. The majority of graduate stu-

dents were employed in teaching positions. Approximately one-third were functioning in expanded role settings.

The program directors were particularly interested to know if the graduates were using the information included in the curriculum. Certain types of activities emerged as common tasks in the day-to-day functioning of the graduates. The knowledge of growth and development was consistently utilized by 70 per cent of the respondents. While this component would be used by any community health nurse, it was strengthened further and reinforced by the program. In specific

TABLE II

THE FREQUENCY THAT THE GRADUATES USED THE INFORMATION INCLUDED IN THE CURRICULUM

	Opportunity to Function						Unrealistic for PNP Functioning	
	Always No.	%	Sometimes No.	%	Never No.	%	No.	%
1. Elicit and record a basic pediatric health history	11	40	10	37	2	7		
2. Perform a pediatric physical assessment	12	44	12	44				
3. Discriminate between normal and abnormal findings on physical assessment and refer for medical consultation when necessary	15	55	7	25	2	7		
4. Identify and utilize knowledge and growth and developmental patterns of infancy and childhood	19	70	6	22				
5. Utilize developmental screening tests and refer for medical consultation when necessary	11	40	12	44	1	3		
6. Assess and manage common childhood illnesses:								
Without physician collaboration	5	18	14	51	6	22	1	3
With physician collaboration	5	18	14	51	2	7		
7. Provide anticipatory guidance in areas such as:								
Nutrition	14	51	10	37	1	3		
Dental	13	48	11	40				
Speech and hearing	11	40	13	48	1	3		
Vision	11	40	11	40	2	7		
Common developmental concerns	18	66	7	25				
8. Recognize and carry out current immunization protocols	11	40	11	40	2	7		
9. Assess family dynamics	12	44	12	44	1	3		
10. Identify and utilize community resources when appropriate	13	48	13	48				
11. Understand the legal aspects of the PNP role	9	33	11	40	1	3		
12. Identify the parameters of role orientation	7	25	13	48	2	7		
13. Articulate the functions of a PNP within the health care delivery system ..	10	37	11	40	1	3		
14. Share decision making in collaboration with physicians	12	44	11	40	1	3		
15. Maintain decision making in situations involving a level of traditional nursing judgments	14	51	12	44	1	3		
16. Provide telephone consultation for:								
Well child care	10	37	9	33	5	18		
Management of minor illness	6	22	13	48	4	14		

SOURCE(S): Guidelines on Short-Term Continuing Education Program for Pediatric Nurse Associates: A Joint Statement of the American Nurses' Association's Division on Maternal and Child Health Nursing Practice and the American Academy of Pediatrics. *Pediatrics*, 45:1075, 1971.

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TABLE III

Please identify the areas in which you feel the quality of care has been improved as a result of care provided by a PNP.

No.	%	
12	44	Greater continuity of care
16	59	More comprehensive care
6	22	Less parental dissatisfaction with care
9	33	More parental satisfaction
2	7	Fewer missed appointments
2	7	Other

areas of skill gained in PNP training, the graduate likewise had opportunity to function; i.e.—obtaining a pediatric health history and performing a pediatric physical assessment. Over 75 per cent of respondents indicated using these skills. Further, they were discriminating findings and referring for consultation as needed.

THE REPORT OF EMPLOYERS

A variety of employers was noted including public health agencies, health centers, physicians and others. Employers responses indicate that employment of PNP's benefited patients by providing greater continuity of care and more comprehensive care in those settings.

Table III is a list of advantages employers report in the use of PNP's.

Table IV shows the PNP salary range. This varied widely and was dependent upon the type of employment and educational preparation.

TABLE IV

Please indicate your current salary range.

No.	%	
1	3	Part Time—2 days/wk—\$50/day
0	0	\$ 8,000 — 8,999
2	7	9,000 — 9,999
1	3	10,000 —10,999
7	25	11,000 —11,999
4	14	12,000 —12,999
6	22	13,000 —13,999
0	0	14,000 —14,999
3	11	15,000 —or above

TABLE V

What type of medical consultation is available for PNP's employed in your organization?

No.	%	
11	40	Physician on premise
8	29	Physician available via telephone consultation
5	18	Standing orders
0	0	No medical consultation
1	3	Other

The graduates work in a variety of clinical settings and carry out their responsibilities in different manners. Forty-eight per cent of employer respondents indicated the PNP carried her own caseload of patients. Medical consultation was available by a physician on the premise as indicated by 40 per cent of respondents or available by telephone as listed by 29 per cent of respondents. Eighteen per cent of the respondents indicated PNP's worked under standing orders, as shown in Table V. All employers who responded found the relationship of PNP to other clinic staff either "very satisfactory" or "satisfactory."

SUMMARY

This information obtained from selected graduates of the University of Iowa PNP Training Program in January, 1975 shows them to be functioning in a variety of settings which include teaching, public health and private practice. The survey data from employers of PNP's shows that it can be a satisfactory professional arrangement, that PNP's make it possible to improve the quality of care.

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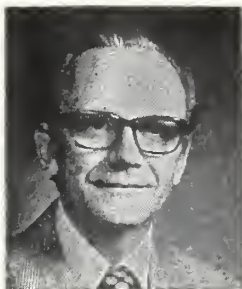
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Editorials

M. E. ALBERTS, M.D., Scientific Editor

EXPERIMENTATION, OR TRIAL AND ERROR

An interesting commentary on medical experimentation on human beings appears in the June 1977 issue of *SCIENTIFIC AMERICAN*.^{*} In the 1950's retrolental fibroplasia reached epidemic proportions among premature infants. Ironically, the epidemic arose from efforts of physicians to increase the chances of the preterm infant to survive. The use of high concentrations of oxygen to overcome respiratory distress resulted in an increased rate of survival, but many of the infants were rendered blind. Silverman reviews the entire story from the first recognition of the heavily vascularized grayish membrane on the rear surface of the optic lens to the eventual conclusion that excessive oxygen was the offending cause. The problem was solved by trial and error.

The question then arises whether it is right to experiment on humans to learn the value and safety of a certain mode of therapy, or to learn of this through trial and error. Silverman argues that this form of approach is like Russian roulette, when compared to efforts to test new treatments with randomized, controlled clinical trials that limit risk. He quotes the French physiologist

Claude Bernard, "Many physicians attack experimentation on human beings, believing that medicine should be a science of observation, but physicians make therapeutic experiments daily on their patients, so this inconsistency cannot stand careful thought. Medicine by its nature is an experimental science but must apply the experimental method systematically."

Silverman believes new federal restrictions on "non-therapeutic" research affecting the human fetus and suckling infants are in a sorry state. He feels that debate about informed consent for experimentation on the fetus and the newborn is pointless. He explains, "Interpretations of risk versus benefit and the social status of these individuals are value judgments that will be decided differently by different subcultures in the society. To impose one solution on everyone is immoral." He feels more, rather than less, experimentation involving human beings, including children, is needed. The point is made that such experiments be carefully designed and surrounded with safeguards. Thus, the medical profession would have a tremendous responsibility if such experiments were permitted, and this is where we come full circle, because the present trial and error approach returns us to the discovery of how tens of thousands of children were blinded by overutilization of oxygen.—M.E.A.

^{*} Silverman, William A.: The lesson of retrolental fibroplasia. *Scientific American*, 236:100-107, June 1977.

MEDICAID/MEDICARE FRAUD AND ABUSE

A press release from the U. S. Department of Health, Education and Welfare on April 29, 1977, reported the results of a survey that shows nine dollars of every \$100 paid by states for Medicaid services to the "medically needy" is spent in error, primarily because of the ineligibility of

recipients. The errors by State agencies or recipients related to Medicaid eligibility or payments total \$980 million in misspent Federal and State dollars. The sampling found that 15.7% of the claims paid by the States on behalf of recipients were in error, of which 9.5% were claims for services to ineligible recipients, and the remainder were computer errors.

(Please turn to next page)

A National Health Insurance Report (7:6, April 11, 1977) indicates the neglect of state lawmakers adds an estimated \$1.5 billion in fraud and abuse costs to the annual Medicaid bill. This report comes from a study by the Human Resources Committee on the National Conference of State Legislatures. The report indicates it is the "duty and function of the state legislators" to provide checks on the program administrators.

Since 1965, Medicaid expenditures have increased by 700 percent—from \$1.6 billion to \$17 billion in costs. The number of recipients has climbed from 9 million in 1965 to 25 million this year.

Some states have taken steps to control Medicaid abuses. New Jersey developed a computer system to detect patterns of fraud and abuse. Pre-processing claims in that state is reported to have saved \$27 million. Wisconsin has established a 30-member strike force against Medicaid fraud. Medicaid recipients in one Minnesota program are restricted to a specific provider for one year when recipient abuse is documented. Other pro-

grams are in the planning stages for better eligibility verification as well as cross-checking of data from other states. As with any bureaucratic program the area is wide open for fraud and abuse. The provision of health care by the government is no exception.

In our dual role as physicians, as well as taxpayers, we should strive to support any responsible and feasible method to decrease the abuses and fraud in the health programs, as well as any other governmental functions. Our country is increasingly plagued by the disease of cheating, fraud, payoffs, and disregard of public trust. It seems to have become a national pastime to "beat the government" out of something.

It would seem entirely justified to publicize the abuses within the actual organizational structure of the health programs, particularly in light of that recently published and blatantly erroneous pronouncement from HEW about Medicare reimbursement to physicians. Only limited correction has been made by HEW of these grievous errors. There seems to be a lot of "green" on the other side of the fence too.—M.E.A.



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State Department of Health

STATUS & PROCEDURES PENICILLINASE PRODUCING N. GONORRHEA (PPNG)

The Center for Disease Control reports 150 cases of PPNG infection reported from 21 states, New York City, and Guam from March 1, 1976, to May 2, 1977. PPNG has also been detected in 16 other countries as well. In the United States the only source of infection caused by PPNG has been importation from the Far East, but several cases in Europe have been linked to sexual contact in West Africa. Significantly, the proportion of cases linked to military personnel or others returning from the Far East has *decreased* dramatically as the organism has spread within the civilian U. S. population. So far, there have been only two laboratory confirmed cases in Iowa.

Successful surveillance for PPNG is largely dependent on the quality of private and public sector patient management, this extends to a health provider's capacity to return patients one week after treatment for test of cure cultures, manage possible treatment failures or reinfections, and provide meaningful counseling-interview services on an ongoing basis.

The Center for Disease Control has recommended the following guidelines:

1. All non-penicillin allergic patients with gonorrhea should receive aqueous procaine penicillin G, 4.8 million units IM with 1 gm of probenecid orally as initial treatment. *Please note the Iowa State Health Department provides replacement drugs for the ampicillin treatment regimen only.*

2. Patients should return in 5-14 days for a test of cure culture.

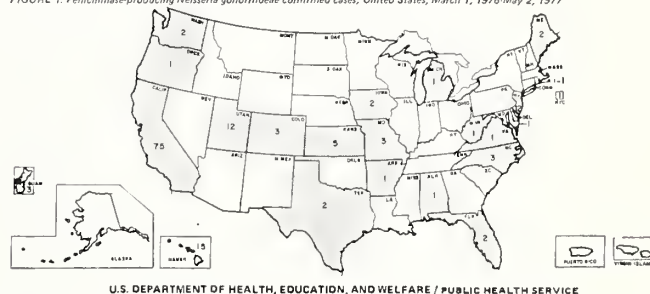
3. Patients with a positive culture should be treated with spectinomycin 2.0 G, IM. Repeat

the test of cure cultures, including throat and rectum sites 3-5 days following this therapy.

4. Positive cultures from patients initially treated with oral or IM penicillin should be submitted for penicillin sensitivity testing. Physicians should contact their state or local health officers *immediately* if penicillinase producing organisms are suspected. *To contact the State Health Department, write or phone: Iowa State Department of Health, Division of Disease Prevention, Lucas Building, Des Moines, Iowa 50319. Telephone (515) 281-3031.*

5. Following the identification of an isolate suspected of penicillinase production, immediate exhaustive epidemiologic followup is necessary.

FIGURE 1. Penicillinase-producing *Neisseria gonorrhoeae* confirmed cases, United States, March 1, 1976-May 2, 1977



U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE / PUBLIC HEALTH SERVICE

Figure 1. Penicillinase-producing *Neisseria gonorrhoeae* confirmed cases, United States, March 1, 1976-May 2, 1977.

- a. All contacts should be provided throat and rectal as well as cervical or urethral cultures.

- b. All contacts (positive or negative) should be treated with spectinomycin 2.0 G, IM.

- c. All positive cultures from contacts (initial as well as subsequent cultures) should be submitted for sensitivity testing.

- d. All contacts with positive cultures should be recultured within 3-5 days following the initial treatment.

The State Hygienic Laboratory in Iowa City
(Please turn to page 408)

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Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

See next page for brief summary.

SUSTAINED ACTION



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CAUTION: Federal law prohibits dispensing Tedral SA without prescription.

Description. Tedral: each tablet contains 130 mg theophylline, 24 mg ephedrine hydrochloride, and 8 mg phenobarbital.

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Tedral Elixir: each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine hydrochloride, and 2 mg phenobarbital; the alcohol content is 15%.

Indications. Tedral, Tedral SA, and Tedral Elixir are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal or perennial asthma.

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These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications. Sensitivity to any of the ingredients; porphyria.

Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Average Dosage. *Prophylactic or Therapeutic.*

Tedral: Adults—One or two tablets every 4 hours. **Children**—(Over 60 lb) one-half the adult dose.

Tedral SA: Adults—One tablet on arising and one tablet 12 hours later. Tablets should not be chewed. **Children**—Not established for children under 12.

Tedral Elixir: Note: One teaspoonful is equivalent to one-quarter Tedral tablet. **Children**—One teaspoonful per 30 lb body weight, every 4-6 hours, unless prescribed otherwise by physician. Should be given to children under 2 years of age only with extreme caution. **Adults**—One to two tablespoonfuls every four hours.

Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

Tedral Elixir: Dark red and cherry-flavored in 474 ml (16 fl oz) bottles (N 0047-0242-16).

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Full information is available on request.

Morbidity Report for August, 1977

Disease	Aug. 1977	1977 to Date	1976 to Date	Most August Cases Reported From These Counties
Amebiasis	6	77	34	Boone
Ascariasis	1	1	11	Sioux
Brucellosis	6	10	12	Dubuque
Chickenpox	12	7374	8982	Scattered
Conjunctivitis	4	1751	1488	Black Hawk
Encephalitis, unsp.	1	3	2	Black Hawk
Erythema				
infectiosum	2	51	154	Mills, Scott
GI viral	121	16380	16308	Scattered
Giardiasis	7	59	17	Scattered
Guillian Barre	2	2	—	Polk, Appanoose
Hepatitis				
A	7	73	91	Scattered
B	16	90	60	Scattered
unspecified	6	28	14	Harrison
Histoplasmosis	1	1	14	Marshall
Impetigo	10	421	451	Black Hawk
Infectious				
mononucleosis	18	726	689	Scattered
Influenza-like				
illness	49	40485	39255	Scattered
Malaria	1	1	—	Woodbury
Meningitis				
aseptic	8	12	10	Scattered
unspecified	6	12	4	Scattered
Meningoencephalitis,				
viral	1	1	1	Dubuque
Mumps	7	1174	1195	Scattered
Pediculosis	9	243	278	Scott
Pertussis (whooping				
cough)	2	2	3	Lyon, Crawford
Pneumonia	50	654	726	Scattered
Rabies in animals	16	86	99	Scattered
Ringworm				
body	1	186	173	Keokuk
scalp	1	7	19	Keokuk
Rubeola	5	4264	37	Scattered
Salmonellosis	36	154	87	Scattered
Scabies	25	596	445	Dubuque, Polk
Shigellosis	11	34	58	Scattered
Streptococcal				
infections	371	8990	11190	Scattered
Tetanus				
(neonatal)	1	1	—	Buchanan
Trichuriasis	2	2	13	Dubuque, Sioux
Tuberculosis				
total ill	7	69	71	Scattered
bacteria positive	7	57	62	Scattered
Venereal diseases				
Gonorrhea	615	3851	4420	Scattered
Syphilis				
other than				
P. & S.	17	208	221	Scattered
P. & S.	2	28	—	Iowa, Linn

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
 Adenovirus—1, Coxsackie B5—2, Coxsackie B3—2, Coxsackie A9
 —1, Cytomegalovirus—1, Eaton's agent infection—5, ECHO Type
 9—3, ECHO Type 6—1, Herpes simplex—11.

STATE DEPARTMENT OF HEALTH

(Continued from page 405)

is testing selected isolates of gonorrhea organisms for penicillinase as part of a state-wide surveillance program. Physicians suspicious of the possibility of a PPNG infection in a patient who has received adequate therapy, may specifically request the beta-lactamase test be performed to confirm the presence of penicillin resistant organisms.

A WORD ABOUT COSTS

Due to serious financial constraints, the Iowa State Department of Health is no longer able to make full replacement of medications which have been used to treat gonorrhea cases and suspects. Presently, the treatment of choice is and remains 4.8 million units of aqueous procaine penicillin G (APPG), intramuscular, together with 1 gm of probenecid by mouth just before the injections. This regimen has advantages of being efficacious for oropharyngeal infection as well as incubating syphilis. However, the costs of APPG make it prohibitive for the Department to issue this antibiotic for routine gonorrhea treatments. Accordingly, the APPG regimen will be replaced with a single oral dose of 3.5 gm ampicillin and one gram of probenecid. In the future, these drugs will be issued upon request of the attending physician for treatment of patients with gonorrhea.

Review of treatment records from the V.D. Clinic, Des Moines/Polk County Health Department, indicate the ampicillin regimen has a 4.2% failure rate; this compares to a 4.7% failure rate for APPG. While ampicillin is ineffective against

The specimen slip submitted to the State Hygienic Laboratory should clearly indicate that the beta-lactamase test is being requested. Current Jembec culture plates should be used to transport specimens and should be incubated overnight if at all possible prior to mailing.

To order Jembec media, write or phone the State Hygienic Laboratory: State Hygienic Laboratory, The University of Iowa, Medical Laboratory Building, Iowa City, Iowa 52241. (Telephone: (319) 353-5990).

oropharyngeal gonorrhea and incubating syphilis, these forms of venereal disease are relatively uncommon in Iowa. Nevertheless, these facts would even more underscore the importance of returning the patients for follow up cultures for gonorrhea and serologic tests for syphilis.

If a patient should present with pharyngeal gonorrhea or have a history of penicillin sensitivity, then tetracycline is the recommended treatment of choice. This drug is available on request from the V.D. Section, State Health Department. In addition, benzathine penicillin G remains the treatment of choice for syphilis. The V.D. Section will supply this drug but only for treatment of cases of less than one year's duration.

In addition to not replacing all medications, the decrease in venereal disease control services also extends to not providing fees to physicians for the examination, diagnosis, and treatment of venereal disease patients. Should the funding situation change, affected physicians will be promptly notified. Despite these handicaps, continued support of venereal disease control activities by private physicians and public agencies is urgently requested.

CONTINUING EDUCATION COURSES & CONFERENCES

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

October 6-8	Training Institute for Physical Therapy Supervisors	November 7-11	Surgical Techniques in Cleft Lip and Palate
October 8	Neurology Update: Current Diagnosis and Therapy	November 10-12	International Workshop on Neuro-Ophthalmology
October 18-19	American Society of Biomechanics	November 10-12	Training Institute for Clinical Educators
October 21-22	Current Trends in Psychiatry	November 16-17	Pastgraduate Conference on Obstetrics and Gynecology
October 24-28	Intensive Course in Pediatric Nutrition	November 17	Radiation Therapy Seminar
October 27	Radiation Therapy Seminar	November 18	Surgery Pastgraduate Conference
November 4	Otolaryngology Clinical Conference	November 19	Cancer Teaching Day

Medical Assistants



by BETTY EHLERT, CMA-A

"AAMA: GOLDEN GATE TO ACHIEVEMENT"

When the American Association of Medical Assistants' 21st annual meeting opens October 17 at the Hotel St. Francis in San Francisco, an anticipated 1,200 medical assistants, educators, students, physicians and other health professionals will discover the meaning of the convention theme "AAMA: Golden Gate to Achievement."

The full week of educational programs, workshops and business sessions will culminate with

the installation of the 1977-78 officers at the Inaugural Banquet on Friday evening, October 21, when President-Elect Jeanne D. Green, CMA-A, Davenport, will be installed as *PRESIDENT*.

Mrs. Green will be honored at a luncheon Wednesday, October 19 given by the Iowa State Society, AAMA. Guests will be national officers, committee chairmen and physician advisors, with Iowa medical assistants serving as hostesses. Iowans are asked to contact Marcine Sanders, CMA-A, Davenport, Luncheon Chairman, upon arrival in San Francisco.

NATIONAL PRESIDENT

The members of the Iowa State Society, AAMA, proudly congratulate Jeanne as she becomes national President of the American Association of



Medical Assistants. She has been an outstanding leader on local, state and national levels. We are very honored now to have her serve as national president.—MARGARET PORTER, CMA-AC, *President, Iowa State Society, AAMA.*

FROM THE BOSS

The following comments are those of James F. Bishop, M.D., Davenport, immediate past president of the Iowa Medical Society and the long-time employer of our new national president. His comments are supported by her fellow Iowa AAMA members.

Some 28 years ago, I needed an office helper and placed an ad in the local paper. The guardian angels must have been feeling especially benign that day when they directed the reply. An association began which has turned out to be one of the better things that has happened to me during my not inconsiderable tenure in medical practice. Jeanne Green joined me at that fortunate time and has become (shh, have to be careful about these things!) well nigh indispensable.

I have known and appreciated for all these years the competence, intellect, steadfastness, and talent which brought her to her present position of national honor.

I congratulate the AAMA for its good judgment and am glad to see my own confirmed.

(Anyone know a good place to brush up on my typing?)

About IOWA Physicians

Dr. Kent Opheim joined **Drs. R. R. Roth, R. D. Flory** and **T. S. Lederman** in family practice in Waterloo in August. Dr. Opheim received the M.D. degree at U. of I. College of Medicine; and recently completed his family practice residency in Oak Park, Illinois. . . . **Dr. M. D. Huffman** has joined Park Physicians, Inc., in Humboldt. Dr. Huffman received the M.D. degree at U. of I. College of Medicine and served his family practice residency at Mercy and St. Luke's Hospitals in Davenport.

Dr. Roger Tan and **Dr. Cora Tan** began family practice in DeWitt in August. Both received the M.D. degree at Santo Tomas in the Philippines and interned at Mercy Hospital in Des Moines. Dr. Roger Tan completed a surgical residency at VA Hospital in Des Moines, and two years of family practice residency at Broadlawns Hospital in Des Moines. Dr. Cora Tan completed her family practice residency at Broadlawns Hospital. . . . **Dr. Michael J. Versackas** has joined **Dr. Louis H. Fingerman** in the practice of ophthalmology in Des Moines. Dr. Versackas received the M.D. degree at U. of I. College of Medicine and completed his residency in ophthalmology at Barnes Hospital in St. Louis, Missouri. Dr. Fingerman recently moved from 1056 Fourth Street to 1212 Pleasant Street, Suite 301, Des Moines, Iowa. . . . **Dr. Kazem Fathie**, Cedar Rapids, was one of 40 neurosurgeons invited to read papers at the International Congress of Neurological Surgeons in Brazil. Dr. Fathie's paper was based on treatment of stroke due to blockade in the arteries of the neck, referred to as transient ischemic attack. He also presented a video cassette produced at CR's Mercy Hospital by the audio-visual department, which showed the patient arriving at the hospital unconscious and paralyzed; the entire operation; and then the patient walking out and going home to a normal life after surgery. . . . **Dr. John**

Justin, Mason City, moderated a recent full-day symposium on perinatal care sponsored by the March of Dimes and the North Iowa Community College. Speakers included **Drs. Herman Hein** and **Frank Zlatnik** of the University of Iowa and **Drs. Gene Garrett** and **Bruce Dunker** of the Park Clinic in Mason City.

Dr. B. O. Murphy, internist, joined **Drs. A. Clark Hyden** and **Edward L. Van Bramer** in Sioux City in August. Dr. Murphy received the M.D. degree at the University of Michigan. He interned and served a residency at Henry Ford Hospital in Detroit, Michigan. . . . **Dr. James E. Powell** began medical practice with **Drs. Donald Faber** and **Daryl Doorenbos** in LeMars in July. A LeMars native, Dr. Powell received the M.D. degree at U. of I.; interned at McKennan Hospital in Sioux Falls, South Dakota and completed his family practice residency at the Sioux Falls Family Practice Center. . . . **Dr. Michael F. E. Jones** began practicing otorhinolaryngology in Sioux City in August. Dr. Jones received the M.D. degree at U. of I.; interned at Valley Medical Center in Fresno, California; served one year in a general surgery residency at Creighton University School of Medicine in Omaha; and completed his residency training at the University of Nebraska Medical Center. . . . **Dr. James A. Peterson, Jr.**, surgeon, has joined the staff at Medical Associates in Clinton. Dr. Peterson received the M.D. degree at the University of Nebraska and recently completed his general surgery residency at the University of Nebraska Medical Center. . . . **Dr. Askar Ali Qalbani** recently joined the Department of Pathology at the Marion Health Center—St. Joseph Unit in Sioux City. Dr. Qalbani received his medical education at Liaquat Medical College, Jamsboro, Pakistan; interned at St. Francis Hospital in Trenton, New Jersey and completed his residency

in anatomic and clinical pathology at Mt. Sinai Hospital in Elmhurst, New York. Prior to locating in Sioux City, he was a project investigator, Department of Pathology, University of Texas in Houston.

Dr. Edward W. Green, surgeon, has joined the medical staff at the Jefferson Clinic. Dr. Green received the M.D. degree at the U. of I. and completed his residency in surgery at University Hospitals. Dr. Green has practiced in southern California for eight years.

DEATHS

Dr. Charles H. Wilson, 56, Manson physician for 21 years, died August 7 at Methodist Hospital in Rochester, Minnesota. Dr. Wilson received the M.D. degree at the U. of I. and interned at Charlestown Hospital in Boston, Mass. A World War II veteran, he began his medical practice in Manson in 1946 following his discharge from the U. S. Navy. He was the founding president of the Board of North Central Iowa Mental Health Center in Fort Dodge and a charter fellow of the American Academy of Family Practice.

Dr. Thomas J. Egan, Bancroft physician for 42 years, died July 25 at Kossuth County Hospital in Algona. Dr. Egan received the M.D. degree at Creighton University School of Medicine in Omaha. Prior to locating in Bancroft, Dr. Egan practiced in Logan, Varina, Ridgeway and Spillville.

Dr. Robert H. McBride, 82, longtime Sioux City pediatrician, died August 31 at a Sioux City hospital. Dr. McBride received the M.D. degree at the U. of I. and served his residency at University Hospitals. He located in Sioux City in 1927 and retired in 1967. Dr. McBride was a past president of Woodbury County Medical Society, member of American Board of Pediatrics, and life member of the Iowa Medical Society and American Medical Association.

Dr. Emmet Rock, 85, retired Davenport physician, died August 9 at Mercy Hospital in Davenport. Dr. Rock received the M.D. degree at the U. of I. and took his postgraduate work at Massachusetts General Hospital in Boston, Massachusetts and the Harvard School of Medicine. He was a past president of the medical staff at Mercy Hospital; past president of the Scott County Medical Society and life member of the Iowa Medical Society.

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MUSCATINE, IOWA—needs two family physicians, obstetrician-gynecologist, ophthalmologist and otolaryngologist. Muscatine has a population of 23,000 and serves an area of 40,000. Construction has started on a new 4.5 million dollar addition and there is a new one million dollar clinic under construction. The community is 30 miles from University of Iowa and 30 miles from the Quad-Cities. Ten new physicians have located here in the last three years. We are continuing to upgrade the quality of medical care given to the community. If you are interested please send curriculum vitae and list of 4 references to David G. Kundel, M.D., Chairman, Recruitment Committee, 1501 Cedar Street, Muscatine, Iowa 52761.

PSYCHIATRIC RESIDENCY—Vacancies for position for January 1, 1978 for those who have a regular Iowa license or can obtain one by reciprocity or via FLEX. Prepare for career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, children's unit, adolescent unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, \$22,360; 2nd year, \$23,478; 3rd year, \$24,674. Intensity and diversity of training program appreciated best by personal visit. Contact T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa, 51012. Equal Opportunity Employer. Call Collect 712/225-2594.

ORTHOPEDIC SURGEON, OPHTHALMOLOGIST, OBSTETRICIAN-GYNECOLOGIST, INTERNIST-CARDIOLOGIST, OTOLARYNGOLOGIST—Wanted to join established 18-man multi-specialty group in north central Iowa. Immediate full financial partnership and outstanding benefits. New clinic building and hospital. Progressive community with excellent schools and recreational facilities. Write No. 1528, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

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President's Page

Iowa physicians have a right to be proud of their monthly journal. It's been recognized as one of the good publications of its type. Last year in a national competition the IMS JOURNAL ranked first among state medical journals in the smaller circulation category.

Our objective with the JOURNAL is to bring worthwhile medical information to the membership—basically in the form of three or four scientific articles written by Iowa physicians. Additionally, each issue contains socio-economic material which bears on the delivery of medical care in Iowa, and news about Iowa doctors.

If our reputation for doing a good job is to be maintained—as it applies to this publication—then innovation must be part of the production effort. So, with an eye toward being innovative, we submit this November issue. Most conspicuous to regular readers will be the new cover design. We hope it will come across as sprightly, distinctive and professional.

Secondly, our editorial thrust this month is essentially non-scientific. We believe the content will be of interest and value to our physician readers, and it may be beneficial to our patients. Thus, we recommend that this issue, after it's read by member physicians, be placed in reception areas for further perusal by those who are interested.

If we provide useful additional information to our patients this way, a good purpose will be served. We'll welcome any reaction about repeating the idea once or twice each year.



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JOURNAL OF THE

Iowa medical society

VOL. 67, No. 11

NOVEMBER 1977

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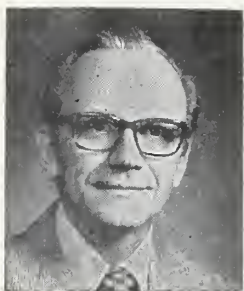
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Editorials

M. E. ALBERTS, M.D., Scientific Editor

A UNIQUE CONCEPT

This issue of THE JOURNAL culminates several months of planning and presents a new editorial concept. Much thought and study has gone into the preparation of this issue. It has been designed for the patients as well as member physicians. Consequently, doctor, after reading this November issue you may wish to place it in your office reception room.

A lay-oriented issue of a medical journal is perhaps unique. If reader reception is satisfactory, maybe such an issue should be presented every year or two. We invite your comments about the new venture.

Subjects presented review the status of medical practice in Iowa. Reports concern the medical

college, physician-patient relationships, plus a new look on the cover. The new cover design is flexible, and for the first time in many years omits an advertising message. Your editorial and managing staff desire to present a publication which is most acceptable to the readers. Our contributors of scientific articles deserve to have their material presented in a good, readable, uncluttered way. We are trying to achieve this goal. In the future, we hope the scientific articles submitted to us will be short and concise so more authors may have their works published. Some journals are limiting the length of published papers, or requesting the author to assist with the cost of pages beyond a specified number. Such a proposition may need our consideration.

We shall do our best to keep our readers informed; we shall also do our best to present a journal which is pleasing to the readers.—M.E.A.

DO DOCTORS MAKE HOUSE CALLS?

Do doctors still make house calls?

Most people say "no." The truth is a lot of doctors still make some house calls. Not as many as a generation ago, to be sure, but more than might be imagined—more than 17 million per year nationally.

Physicians generally agree they can do more for their patients in the hospital or office, where diagnostic equipment and skilled staff are at hand. But all also admit under certain circumstances,

the house call can be an effective and important facet of the physician-patient relationship.

The most recent statistics available show more than 17 million house calls made annually in the United States. This means about 2 per cent of all physician services are being delivered at home. Visits to elderly patients—persons 65 and older—are the most prevalent, accounting for 51 per cent of all house calls. General practitioners or family physicians make 77 per cent of the home visits.

Patients of all income levels are visited at home. About 40 per cent of those seen are in families having an annual income of less than \$5,000, with 25 per cent under \$3,000. Another 40 per cent are earning \$10,000 and over.

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Iowa's Medical Care Scene

They say a picture is worth a thousand words. If this is true the next several pages have a lot to say—about Iowans caring for Iowans. The jobs performed by these individuals are exceedingly important. They require skill, knowledge and the ability to accept and assume responsibility. At this season of the year, it's appropriate to be thankful for the total and hard-working Iowa health care team.

THE IMPORTANCE of good health to Iowa's approximately 2,830,000 inhabitants is obvious.

Without it, the 189,100 agricultural workers on Iowa's 131,000 farms would be hard pressed to continue providing the nation with nearly 10 per cent of its food supply.

Without it, the productivity of the state's 238,600 industrial workers would be endangered, and the 19 billion dollars worth of Iowa manufactured products would almost certainly dwindle.

Without it, the 32,000 educators in Iowa's public and private elementary and secondary schools would be handicapped mightily in their teaching

tasks. And the state's claim on one of the highest functional literacy rates in the nation would be threatened.

See Page 428 for Picture Identifications

Simply stated, without good health, the state's 1,391,210-member work force—and their families—would be in jeopardy.

Good health comes to a person or family as a consequence of varying actions. Most critical perhaps is the action of the individual in maintain-

GUIDELINES ON WHEN TO SEE THE DOCTOR

All Iowans now and then face a quick decision: Should we, or shouldn't we see the doctor?

The medical profession has compiled several points to use as a general guide in deciding if medical aid should be sought at once—

• • •

- When the complaint or symptoms are too severe to be endured, such as abdominal pain common to a gall bladder attack or appendicitis or kidney colic, or sudden chest pains. Immediate relief of pain is the purpose of getting the patient to the doctor without delay.

• • •

- When an apparently minor symptom persists for more than a few days or a week, and does not appear to be due to some easily identified cause. A nose bleed from a sharp blow is one thing; a nose that bleeds constantly or frequently for no apparent reason is quite a different matter.

• • •

- When the symptom returns repeatedly for no readily apparent cause. Digestive disturbances due to overindulgence are one thing; constant digestive distress despite great care and moderation in eating is another.

• • •

- When in doubt, it is safer to call the doctor than to take a chance.

Many accidents around the home or yard cause bruises and scratches and minor sprains that can be successfully treated at home. But some accidents require fast medical attention.

• • •

If the accident victim is unconscious, get help fast. Also when bleeding is severe or cannot be controlled; when the victim is groggy or confused; when there are signs of shock, such as pale, cold skin, sweating and weak pulse.

Breathlessness or intensive thirst after the accident require medical attention. If there is a possible broken bone, seek help. Also for severe pain, signs of poisoning, serious burns, persistent vomiting, blurred vision.

IOWA'S MEDICAL CARE SCENE

(Continued from page 423)

ing his or her own health. Involved here is what's sometimes called *lifestyle*. Proper nutrition. Adequate exercise and rest. Satisfactory living and working conditions. Good judgment with respect to use of alcohol, tobacco, etc. Sound behavior in automobiles. And so forth.

Good health care goes a step further. This refers to preventing disease, responding to a symptom, treating an injury. Of importance here is the individual's ability to set priorities and to know when, how and where to seek assistance. When a signal comes that a potential health problem exists, the individual must judge for himself or his family member if the matter needs the care and attention of a physician. Some guides are provided with this discussion.

ESTABLISHED RELATION

When a decision is made that the assistance of a physician is necessary, the individual or family having an established relationship with a specific doctor is generally in a more favorable position. The services of some 3,000 physicians are available in the State of Iowa at this time. Approximately a third of these doctors are general or family practitioners. Developments today—in medical education—are beginning to have a favorable impact on the number of family practitioners locating in various-sized Iowa communities.

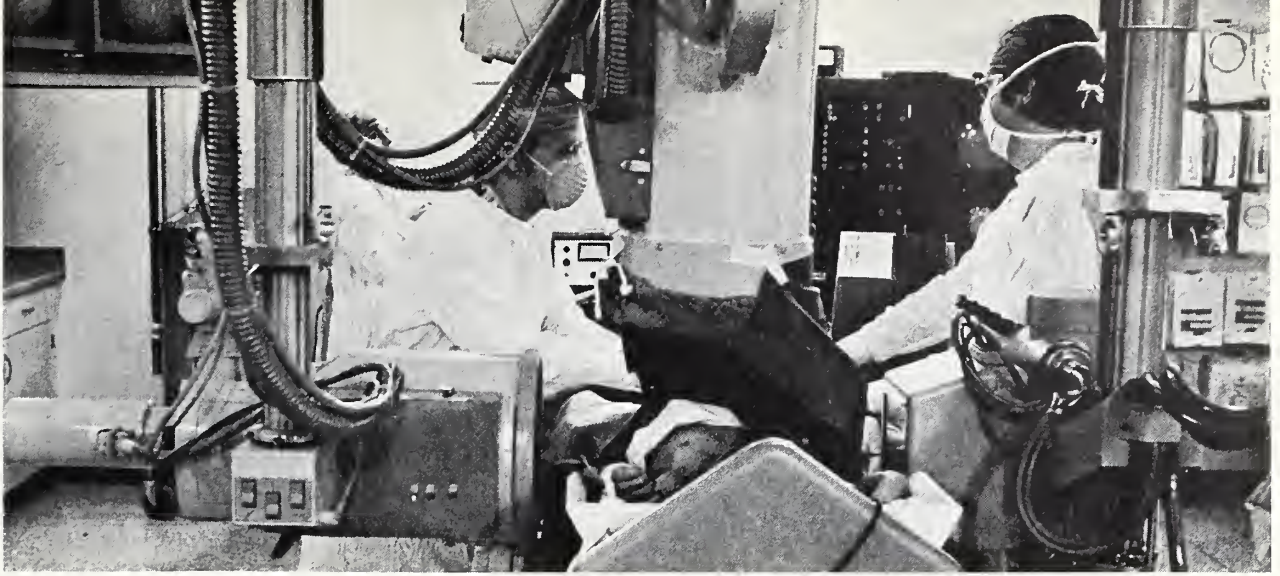
Supporting the physician members of the Iowa health care team are 60,000-plus others who perform a myriad of valuable tasks, ranging from the highly complicated to the very fundamental. These individuals work in offices, clinics, laboratories, hospitals, nursing homes, pharmacies, the full gamut of health care facilities.

In the major and acute realm of the hospital, Iowa has 146 such facilities located in 113 communities. There are in excess of 40,000 hospital employees and probably 50,000 others who volunteer some of their time to assist in the care of hospitalized Iowans.

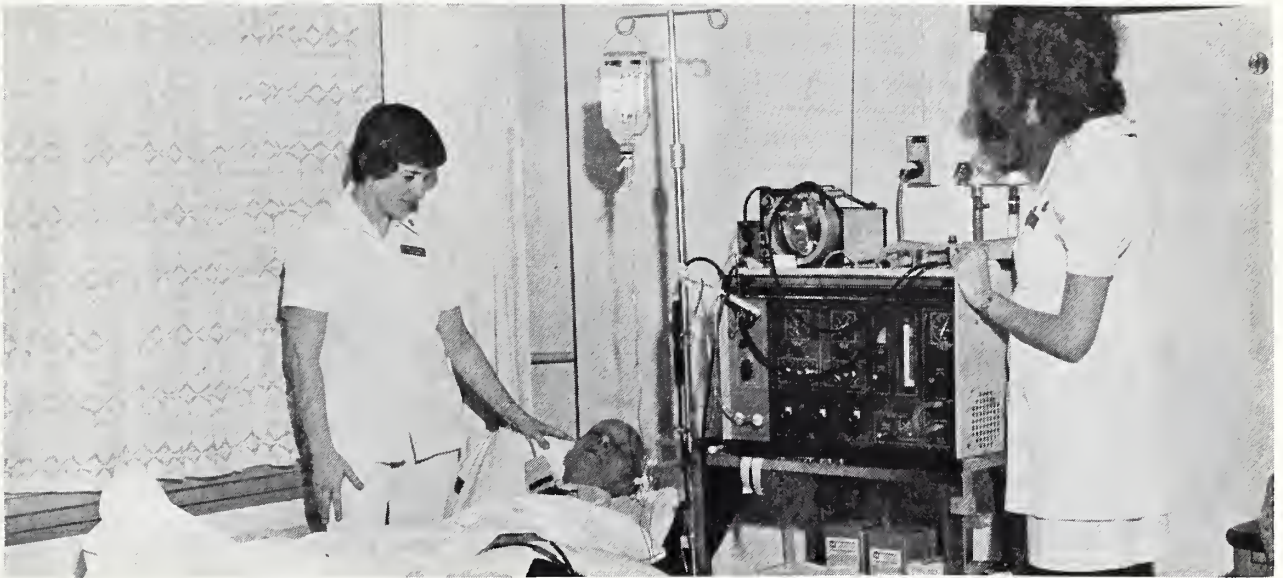
The accompanying pictures taken in randomly chosen Iowa hospitals show graphically what's happening on the medical care scene in 1977. They depict a humanity-serving enterprise of major dimension. Last year Iowa hospitals reported 571,731 inpatient admissions and a total operating expense of \$641 million.

Today, members of the Iowa health care team

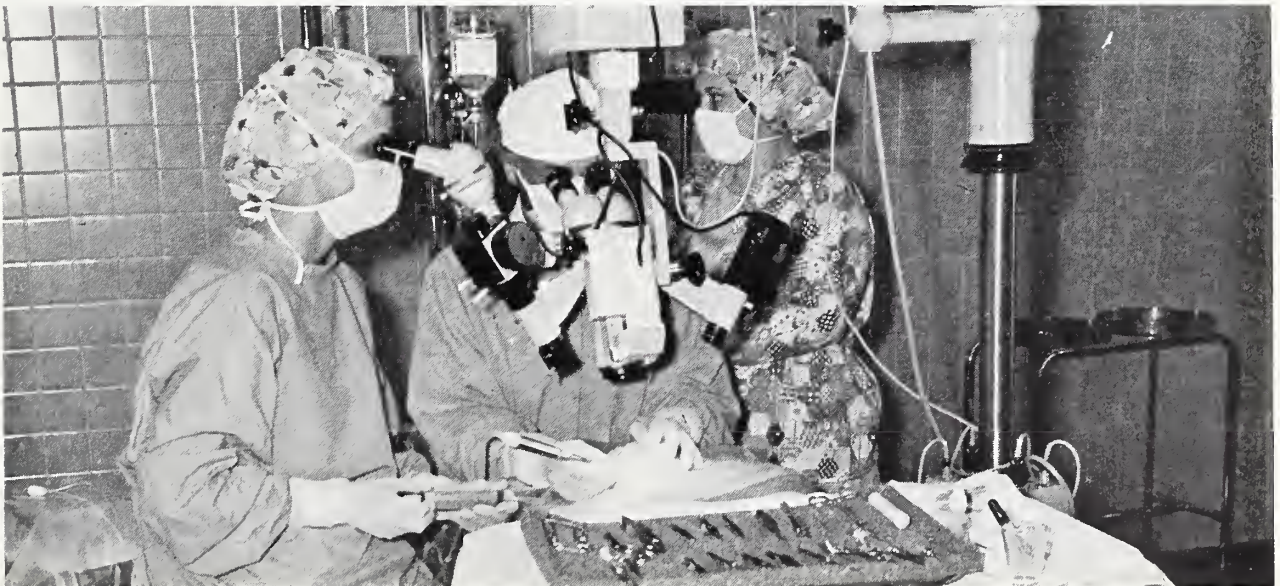
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IOWA'S MEDICAL CARE SCENE

(Continued from page 424)

have long-standing objectives to pursue—to protect, maintain and restore the health of their fellow citizens. But their approach to these objectives is substantially different from that of a generation or two ago. The application of modern medicinals, the use of newly developed surgical techniques, the availability of sophisticated mechanical devices make medical care far different from the turn of the century when compassion, thoughtful attention and time were the major tools in the medical care armamentarium. Today these items are equally important but they have been generously and effectively supplemented.

THE FUTURE

Perhaps the most conclusive statement that can be made about the future of Iowa health care delivery is that it is now under intensive study. Part of a huge national investment (in tax dollars) is being spent in Iowa on health planning. This current statutory effort to decide what approach(es) will best serve the future needs of our citizens constitutes undoubtedly the most auspicious health chapter in the history of governmental planning. Will the outcome be meaningful and beneficial to people of Iowa, particularly in relation to the investment? *Only time will tell.*

Planning can be expected to dominate the health care equation for a period of years. In this planning process attention must focus on cost effectiveness—that challenging and all-important effort to preserve the quality and availability of medical care services while restraining the dollar outlay. This awesome assignment goes beyond our ability to discuss in this space. Suffice it to say that, very logically, each person wants the best available medical care for himself and his family. Relating this instinctive motivation to the economic capacity of our state and nation is the formidable chore we face in the years ahead.

With these few words and pictures we mean not to offer solutions. We want simply to cite the physicians, nurses, technicians, etc., who are part of the here and now. We refer to those who are shown here at work in Iowa in 1977, as well as their unpictured associates. In the vast majority, these persons are conscientiously delivering service to the ill, the injured and the infirm. While the effort to do better should forever be part of their chemistry, the knowledge that they are serving to the best of their ability is deserving of recognition.



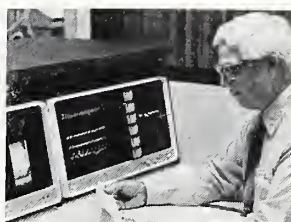
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AMERICANS SATISFIED WITH HEALTH CARE

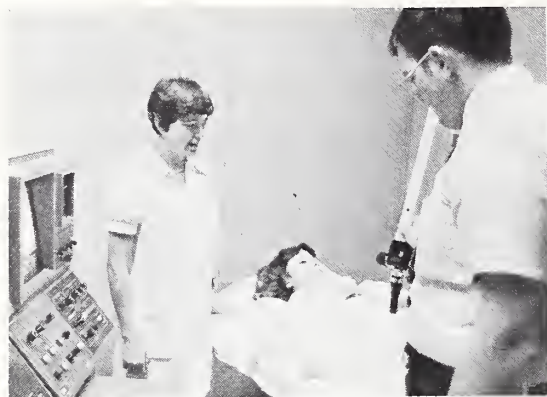
Most Americans are well satisfied with the quality of their health care, according to a Gallup survey reported in late September.

Americans as a whole rate health care quality quite high, the survey found. Even some groups often thought to be deprived—the *elderly and rural residents*—believe they receive high quality care and are well satisfied with it.

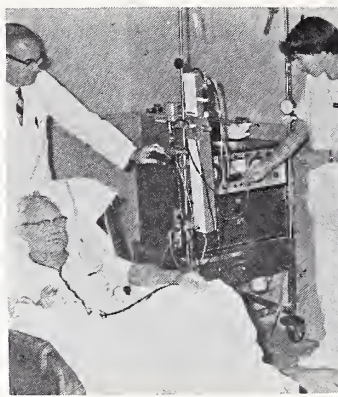
The survey also found the public isn't worried about financing the usual cost of health care, mostly through health insurance. Over half even

felt they could meet the costs of a major, long-term illness.

The following survey percentages are of interest: (1) 90% were satisfied with their last visit to a medical doctor; (2) 69% felt confident in their ability to pay the usual costs of health care; (3) a lesser number, 51%, are confident they could finance a major illness; (4) 67% thought there is a need for national health insurance, but this dropped to 40% when it is realized that added taxes will finance such a program.



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PHOTO IDENTIFICATIONS—1/Emergency care as delivered at Cass County (Atlantic) Memorial Hospital with Keith Swanson, M.D., and nurses ready to serve. 2/Ronald Lauer, M.D. (left foreground), professor and director of the Pediatric Cardiovascular Center at the University of Iowa Hospitals and Clinics, heads a cardiac catheterization procedure, one of nearly 300 performed annually on infants and children. 3/The renal dialysis unit in operation at St. Luke's Hospital in Davenport. 4/A vitrectomy procedure is performed by Massoud Shahidi, M.D., at Mary Greeley Memorial Hospital in Ames. Assisting Dr. Shahidi is Pat Folkmann, R.N., left. 5/New stress test equipment at Cass County Memorial Hospital. The patient walks the treadmill while a nurse checks blood pressure and Thomas J. Payne, M.D., reads the viagraph system. 6/J. L. Hizon, M.D., left, chief of psychiatric services, joins patients in occupational therapy which is part of the 20-bed psychiatric unit at Trinity Regional Hospital in Ft. Dodge. 7/University of Iowa Hospitals' 18-million volt linear accelerator uses either photons or electrons for cancer treatment. H. B. Latourette, M.D., right, professor and head of radiation therapy division, and RT Technologist Judith Wach position a patient. 8/Infant is examined by Donald Ryerson, M.D., in special care nursery in obstetrical unit at Trinity Regional Hospital in Ft. Dodge. 9/R. E. Joranson, M.D., scrutinizes a patient's EKG printout from a control monitor at Jennie Edmundson Hospital in Council Bluffs. 10/Student Nurse Jane Barbara Hughes discusses a patient with Dennis H. Kelly, M.D., at the Iowa Methodist Medical Center in Des Moines. 11/Cardiologist Hugo E. Koo, M.D., performs an echocardiogram and phonocardiogram at Allen Memorial Hospital in Waterloo. Cardiac catheterization capability will be available at Allen in 1978. 12/R. K. Green, M.D., utilizes a grey scale ultrasound in evaluating his patient at Jennie Edmundson Hospital in Council Bluffs. 13/Patient Howard Temple is treated in the hemodialysis unit at Ames' Mary Greeley Hospital. Assisting are George Montgomery, M.D., and Deb Sanders, R.N. 14/Sharon Burgus, R.N., checks blood pressure on a young patient at Blank Memorial Children's Hospital in Des Moines. 15/View of the cardiac stress test laboratory at St. Luke's Hospital in Davenport. 16/Liberato Iannone, M.D., cardiologist at Mercy Hospital, Des Moines, and Radiological Technician Jim Allison, prepare a patient for a coronary angiogram.

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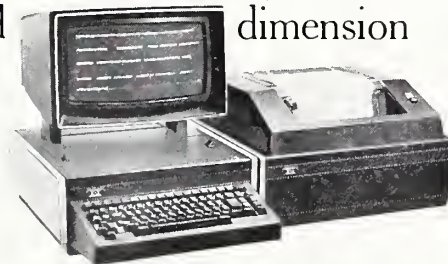
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TWO VIEWS OF



JAMES F. BISHOP, M.D.
Davenport

Physicians must do all they can to help restrain the increasing costs of health care. When the outlay for these services rises above people's ability to pay, the further participation of Uncle Sam is invited. He's been trying to deliver the mail for 200 years—and would like nothing better than to try his hand at being a good, cheap family doctor.

WE ARE TOLD that health care costs are eight per cent of the gross national product and that this is too high. One can only wonder if there is a magic percentage of the GNP which should be allotted to health care. One wonders, too, about access to modern, expensive techniques of diagnosis and treatment. Should this be restricted somehow to limit total costs? The recent denial of payment for CAT (computerized axial tomography) scan examinations for Medicaid patients seems to point this way. The restrictions on expenditures for buildings and equipment in both the public and private sectors underline the idea. Yet the physician wants his patient to have the benefit of the most modern measures. And we had better believe the patient wants them too, regardless of the cost.

These points must be kept in mind in any effort to study and contend with the steadily rising costs of health care.

Easily identifiable are the four principal participants in the health care cost picture. They are *the physician, the hospital, the insurer, and the*

patient. We concern ourselves here only with the one we know best, *the physician*, although there are significant areas in which the other three can mend their ways.

PHYSICIAN RESPONSIBILITY

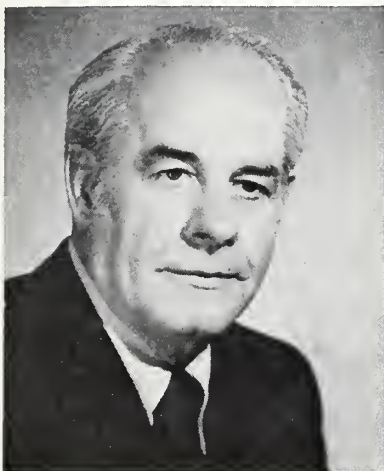
The physician commits a significant percentage of the health care dollar through his activities. Here we encounter at once the charges he makes for his services and those rendered in his office under his direct supervision. These charges must provide for his overhead which may range from a third to more than a half of his gross collections. This overhead, as we all know who have to meet it, rises at the same inexorable pace as everything else in modern society. The acceleration in the costs of some things, such as liability insurance premiums, is even more breath-taking. Unless the physician is employed by a corporation, he must pay, from funds already taxed, for all those goodies known as fringe benefits that come free to employees, even his own.

The physician also controls, to a large extent, all those things done upon his order. He orders hospitalization and the length of stay. Operating rooms and delivery rooms are available to him

(Please turn to page 432)

Dr. Bishop is in the private practice of proctology. He is a member of the Iowa Cost Effectiveness Committee and is immediate past president of the Iowa Medical Society.

HEALTH CARE COSTS



DAVID S. NEUGENT
Des Moines

There really aren't many options left! Either we begin self-regulation through every available channel or health care costs will continue their disproportionate rise, and we will be completely government regulated. The effort must be a joint one of hospitals, physicians, consumers and third party payors. There is an urgency that we begin.

THE CONCERN over health care costs is no different in Iowa than elsewhere in the nation. There may be some slight variations on the theme, but all over the United States, the theme is the same: health care costs are high and are getting higher.

For many years, consumers appeared not to notice what was happening to health care costs. This has been attributed to the fact that a large percentage of the expenditures for health care services are not paid directly by the consumer but by third party payors or the government. The mechanisms of third party payments, payroll deductions, and direct employer and union negotiations tend to shield consumers from the reality of costs.

Third party payments, including government payments, constituted \$118.3 billion of the total \$140.1 billion spent for health care in 1976. Private medical insurance financed \$59.4 billion, and federal, state and local government programs financed \$58.9 billion. This means public funds are paying for more than 40 per cent of the nation's health care.

Mr. Neugent is president of Blue Cross of Iowa and in that capacity directs the distribution of major sums of money paid for medical care provided to the citizens of Iowa.

Health expenditures nationally have tripled since 1965, the year before Medicare. Medicare and Medicaid and other federal programs have had an effect on the frequency with which medical facilities and services are being used. Through these programs, millions of Americans who previously received little or no care are now receiving treatment. But these millions of Americans have affected the utilization rates of health care facilities, and utilization rates affect costs.

HALF FROM GOVERNMENT

Since we serve Iowans as intermediaries in the Medicare, Medicaid and other federal programs, more than half of the benefits delivered by Blue Cross and Blue Shield of Iowa are paid for with government funds. We have watched the government funding of these programs grow in Iowa from \$108 million in 1971 to \$235 million in 1976, a growth of 116 per cent. During the same period of time, the participants in the programs increased 25 per cent.

The result is that both locally and nationally, the public is becoming concerned with how their tax dollars and their health care dollars are being

(Please turn to page 433)

TWO VIEWS ON HEALTH COSTS

J. F. BISHOP, M.D.

(Continued from page 430)

and his patient. Specialized facilities—coronary care and intensive care units, physiotherapy, among others—are at his command. A steadily increasing host of laboratory studies await his pen upon the order sheet. That service, once called x-ray, but now better termed the department of energy emanations, places all its skills and its contraptions at the physician's disposal. A bewildering array of medications awaits his eye in the Physicians Desk Reference and assails his ears in the memorized lectures of the detail persons.

Now, having taken a quick look at this sobering array of goods and services, all rather expensive and readily available, what to do about it?

THE CHALLENGE

First, let us ponder hospitalization. It is expensive to hospitalize. And this area of cost seems to be increasing at a more rapid rate than the other elements of care. I have made some inquiries among hospitals, laboratories, and x-ray services in our area. The information I sought was freely given. It becomes apparent at once that x-ray and laboratory examinations cost less when done outside the hospital. This is without any consideration of room costs, since the hospital laboratory and x-ray charges are essentially the same for inpatients and outpatients. I will not involve us in mitigating circumstances here on either side but only point out the fact. The fact makes it desirable that, if the patient's condition permits, as much as possible of this work should be done prior to, or even instead of, admission.

The need for hospital admission often deserves more consideration than it seems to get. For example, it is not uncommon that when a patient telephones his physician to say he has passed some blood from his bowel, he is admitted to the hospital forthwith. While such a symptom may be an ominous one it is more likely to be innocent and an outpatient investigation can be made.

In one of our Davenport hospitals the daily rate for the most common private room is \$101 and the most common semi-private daily rate is \$96, while the charge in intensive care is \$230 per day. It seems likely that hospitals in Iowan urban areas have comparable rates. If a patient can be safely moved from intensive care to the floor one day sooner, his hospital bill will be reduced \$129 or

\$134, depending upon his accommodations. If he can be safely discharged a day earlier, his bill will be reduced by \$96 or \$101. Always keeping in mind the patient's well being, alertness to such opportunities, if multiplied by several hundred patients, can result in an impressive decrease in costs.

DEFENSIVE MEDICINE

Many times one will think this or that lab test or x-ray would be nice. It fits the currently popular idea of practicing defensive medicine. Solid clinical judgement should determine which examinations are needed and they should be ordered with a rifle instead of a shotgun.

These things and many others can be watched by physicians to help make health care costs more reasonable. The profession's active role in peer review and utilization committees demonstrates a genuine concern in this subject area.

We can, of course, show restraint in raising fees so they reflect only the element of inflation. If we continue trying, wherever we can, to restrain the rising costs of health care without allowing impairment of its quality, we can hope to continue the system I like to call *Private Enterprise Socialism*. Through the process of hard American bargaining, the labor unions have won for their mem-

"We must do all we can to preserve . . . this system. It makes provision for millions . . . to have health care . . . more efficient than any government type of socialism."

bers a growing list of so-called fringe benefits which include medical and hospital insurance. These benefits are paid for by the public through increased prices for the goods and services involved, prices arrived at by market competition.

We must do all we can to preserve and protect this system. It makes provision for millions of our citizens to have health care, it is more efficient and economical than any governmental type of socialism, and it is of practical and material benefit to the medical profession. Very few patients could pay from their own resources the charges paid in their behalf under this *Private Enterprise Socialism*.

We must do all we can to help restrain the increasing costs of health care for they do, indeed, threaten to rise above people's ability to buy them. This invites the further participation of Big Uncle. Uncle Sam has tried for 200 years to deliver the mail. Now he would like to try his hand at being a good, cheap family doctor.

TWO VIEWS ON HEALTH COSTS

DAVID S. NEUGENT

(Continued from page 431)

spent, and the health care industry is entering a new era of public accountability. It has become necessary for the various elements of the industry to be able to trace the causes of health care escalation to justify the present costs. We must become self regulating as far as costs are concerned before the public demands more government regulation. There is no time to lose. We cannot comfort ourselves that we've helped heal society's illness and have helped mend people's bodies if, in the process, we've overlooked society's other needs.

How do we trace the causes of the cost escalation? We can begin with the most obvious cause, the one that is shared with all industries—inflation! Wages and benefits for hospital employees must compete with those of business and industry to attract the necessary skilled workers. Inflation also has increased the cost of the hospital's market basket significantly, and that market basket includes some of the most expensive and sophisticated equipment and services around. The number of clinical laboratory tests per patient day continues to increase year after year as continued research and new technology constantly improve medical services. Today medical science can more or less routinely deal with some conditions that were once thought hopeless. While this has meant a period of tremendous gains in easing human suffering, these gains have been achieved through sophisticated technology and procedures that are invariably expensive to develop and often expensive to operate and maintain.

PHYSICIANS' CHARGES

As with hospitals, inflation accounts for a large percentage of the rise in physicians' charges. Since 1974 these charges have increased 20 per cent, and 14 per cent of this increase may be attributed to inflation. The 1974 wage and price freeze for the medical community kept physicians' fee rises to 2.5 per cent a year. But during this time the physician was paying increasing charges for utilities, supplies, rent, employee salaries and fringe benefit programs. So once the freeze was lifted, fees had to be raised to cover these costs.

Both hospitals and physicians have been faced with increasing costs for malpractice insurance. A survey of 20 Iowa hospitals, conducted by the Iowa Hospital Association in October 1976, reveal-

ed that, from 1973 to 1974 the average rates per patient day rose 33 cents because of the hospitals' costs for malpractice insurance. According to the American Medical Association, the average fee for a doctor's office visit in 1975 was 96 cents higher than it would have been if malpractice insurance rates had remained at the 1973 level. In fact, the AMA estimates that 8.1 per cent of the 1975 average physician fee was for malpractice insurance.

Because of the threat of malpractice litigation and because patients' families often demand it, more physicians are giving the tests that provide the last five per cent of diagnostic certainty. However, the cost of providing these tests continues to rise and accounts for some of the increased incidence in using physicians' services.

SURPLUS BEDS

The one last factor which critics speak of when discussing escalating health care costs is that of surplus hospital beds. These surplus beds frequently can be attributed to the unchecked expansion of hospital building under Hill-Burton funds. The total number of all hospital beds in the United States peaked in the 1960s and has been declining since then. But the decline has been in

"Iowa's hospitals have a current occupancy rate of 68%, the tenth lowest in the nation. The national average . . . rate is 75%, and HEW is calling for a national rate of 80% . . ."

beds for general hospitals and beds in federal hospitals. Short-term care beds in general hospitals have been increasing at a rate greater than the population growth. Since 1960 the non-federal hospital beds for short-term and other care in general hospitals has increased more than 45 per cent while the ratio of such beds to the population increased more than 20 per cent (from 3.6 beds per thousand population to 4.4).

Iowa's hospitals have a current occupancy rate of 68 per cent, the tenth lowest in the nation. The national average U. S. hospital occupancy rate is currently at 75 per cent, and HEW is calling for a national rate of 80 per cent and 4 beds per thousand population, maximum, with a preferred rate of 3.7 beds per thousand.

The rates paid by subscribers to Blue Cross and Blue Shield of Iowa reflect what has been happening to health care costs in Iowa. In the last five years, the cost of our privately financed benefits has more than doubled although subscriber

(Please turn to page 434)

TWO VIEWS ON HEALTH COSTS DAVID S. NEUGENT

(Continued from page 433)

enrollment has increased less than 19 per cent. In 1971 we paid out \$107 million in claims for Blue Cross and Blue Shield Plan subscribers, and by 1976 the amount has grown to \$226 million. If we disregard the expanded enrollment, the privately financed benefit costs still would have increased \$9.6 million.

So, the problem is real, the causes can be traced, and the situation today is critical for members of the health care industry. This is the age of the consumer; we cannot disregard the fact and expect that the industry will survive as we know it. Today's consumer is younger, better educated and better organized than yesterday's consumer, and, most importantly, today's consumer can be characterized as feeling that he or she has a right to health care. That means access to the needed care and a reasonable quality of care.

LIMITED OPTIONS

We really haven't many options left. Either we begin self-regulation through every available channel open to us, or health care costs will continue

their disproportionate rise and we will be completely government regulated. I cannot spell out how this is to be accomplished because it *must* be a joint effort of hospitals, physicians, consumers and third party payors. But I can and will suggest some starting points.

It's time we reconsidered some current concepts and practices that affect health care costs. We all need to re-evaluate the use of outpatient treatment, to question the balance of new technological advances and equipment versus their cost and proven benefit, and to redefine what we mean by accessibility in the delivery of health care. Perhaps most of all, we need to become more positive and vocal about the responsibility of individuals to maintain their own health and to adopt more positive lifestyles, and to educate the public about the cost for medical and health personnel to repair the damage caused by a lifetime of incontinence and excess.

But these are only suggested beginnings, and we mustn't assume that they are conclusions. We may reasonably expect continuing changes in society and we also may reasonably expect that the health care industry will need to continue to respond to new situations. The urgency is that we begin.

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The Question Box



By ROBERT J. CORRY, M.D.

RENAL TRANSPLANTATION IN IOWA

Dr. Corry is professor of surgery and director, Transplantation Service, University of Iowa Hospitals and Clinics. He comments briefly here on the status of the transplant program in Iowa City.

What is the current status of the Iowa Renal Transplant Program?

Over 300 renal transplants have been performed at The University of Iowa. Transplant patients are cared for at both the University Hospital and Veterans' Administration Hospital. During the last four years, we have averaged 60 renal transplants per year. Approximately one-third of the transplants are donated by family members, and the other two-thirds come from cadaver donors. Two year survival of live-related kidneys is 75%, while recipient survival is 97%. Overall cadaver transplant survival at two years is 59%, and patient survival is 85%. When poor-risk patients, including juvenile-onset diabetics and those over 50 are excluded from the statistics, cadaver graft survival is 64% at two years and patient survival is 87%.

Has substantial progress been made in identifying factors influencing survival of renal transplants and their recipients?

Yes. In our Center, Richard M. Freeman, M.D., and I have shown that administration of leukocyte-poor blood to the recipient in the months preceding renal transplantation has been associated with an increase in one and two year graft survival by 15%. Secondly, evidence is being presented from other centers suggesting that pretreatment of cadaver donors with massive intravenous doses of Cyclophosphamide and Methylprednisolone is associated with a partial abrogation of the initial rejection episode, and a better

graft survival. The mechanism for this phenomenon is the elimination of the passenger leukocytes present in the graft which are, at least in part, responsible for sensitization of the host. Most of our cadaver donors have been genotyped by obtaining blood from donors' families at the time permission is obtained. John S. Thompson, M.D., Director of our Histocompatibility Laboratory, has shown improved survival of kidneys matched for a haplotype with their recipient. The effectiveness of antilymphocyte globulin as an immunosuppressant is still undetermined. A multi-center prospective study has failed to show a beneficial effect of antilymphocyte globulin.

Is the Iowa Program keeping pace?

Our program is about the fifth or sixth largest in the United States, and our results, in terms of low mortality and graft survival, are at the top. For example, the one year survival of cadaver kidneys matched for a haplotype is 71%, and our cadaver recipient survival, excluding the poor-risk patients, is 93% at one year. As better methods of planned specific alteration of the recipient's immune responsiveness to foreign tissue antigens are worked out, transplantation of unrelated kidneys will become even more successful.

In what ways can Iowa doctors be useful in supporting the Program?

The Iowa physicians have been very helpful up to now in terms of identifying potential cadaver donors in various intensive care units throughout the state. In 1976, we harvested 78 organs compared to 32 in 1974. I think that these figures show that Iowa physicians have already been extremely helpful in supporting our Program. If more organs are available, then better matches can be obtained, and kidneys can be shared with other centers throughout the United States and Europe when good matches are not available in Iowa.

Over 600 Iowa Physicians Choose IMS/Aetna Insurance Program

THE SCARCITY (and concomitant high cost) of malpractice insurance reached a grave level not too many months ago. The situation seriously threatened the delivery of medical care in some parts of the country. The limited (and even non-existent) market for this coverage produced various alarming responses all across the nation.

In Iowa the medical profession became deeply involved in trying to restore a market for this important form of insurance coverage. Various alternatives were scrupulously explored. Passage of legislation (H.F. 803) in 1975 demonstrated public and legislative awareness of the dilemma. One further response in Iowa took the form of a new program bringing together the Aetna Life & Casualty and the Iowa Medical Society.

The IMS/Aetna Liability Insurance Program

How are the premiums determined?

There are seven classifications for rating purposes. The rates vary from \$924 for a Class 1 physician to \$8,931 for a Class 7 surgeon. The limits of primary professional liability are \$100,000/\$300,000 for physicians and \$250,000/\$500,000 for surgeons; the classifications (and corresponding rates) are based on the individual practitioner's specialty and whether he/she performs no surgery, minor surgery, or major surgery. There are several specific procedures which may influence the assignment of a classification because of their historical claim frequency and severity. To determine precise premiums it is necessary to review an individual practice situation with the nearest Aetna agent or contact Mr. Darrell Chapman, the IMS/Aetna account supervisor in Des Moines at 1/800-362-1809 or 515-244-5145, Extension 222.

Is excess or umbrella coverage available in the program?

Yes. Both professional and personal liability coverage of the excess or umbrella nature is

became operative officially in March, 1977. In the time since, a conscientious effort has been made to explain the program's provisions, the costs and other factors of interest to IMS member physicians. As a consequence of these efforts—and even with a competitive market somewhat restored—a good level of early participation has been achieved. There are now close to 650 Iowa physicians participating in the IMS/Aetna program.

The questions asked most frequently about the IMS/Aetna are about six-fold. To assist those Iowa physicians who have an interest in the program and want to know more about it, the JOURNAL presents these questions here together with brief answers. It is hoped the attempt at clarification will be somewhat helpful.

available at following levels: \$1 million, \$2 million or \$5 million. This is called the catastrophe insurance phase. This along with the primary professional liability and the premises liability are mandatory features of the insurance package. In other words, to become a participant, you must accept all three parts. The rates for the catastrophe insurance program, for the professional liability exposures, range from \$289 for a Class 1 physician to \$1,878 for a Class 7 surgeon.

Are the rates guaranteed?

The availability of the insurance package (as outlined in the brochure mailed by the Iowa Medical Society in March) is guaranteed for three years. Thus, a stable market is assured. Rates, however, will be determined on the basis of experience during each policy year. A loss control and education program has been instituted to attempt to influence and control the claim frequency and severity. The rates for eight other states where the Aetna has similar sponsored programs provide a barometer. There were no increases in five of the states in 1977. Rate increases for the remaining three states did not exceed 10%.

(Please turn to page 438)

Your malpractice insurance is no place to gamble

Professional Liability insurance is one area where it pays to be certain. Certain that you have the most comprehensive coverage possible for your insurance dollar. By purchasing your insurance through your Iowa Medical Society sponsored program you can make the value of your dollar go further thanks to the mass buying power of the Society.

Aetna Life & Casualty has designed a program for IMS offering members the high limits of coverage demanded by today's medical realities. Your total insurance cost may be significantly reduced as a result of a special dividend plan developed by Aetna for the IMS. This is possible, in part, through a Program of Loss Control and Education. By helping you and your staff avoid malpractice pitfalls, the Program helps you control losses.

Don't go it alone when it comes to your all-important Professional Liability Coverage. Be certain and join the other IMS members now insuring through this outstanding Aetna program. Contact your local Aetna agent or fill out the coupon below and we'll provide the details.

Play safe
with the IMS-
sponsored
program.

IMS

Aetna
LIFE & CASUALTY

The Iowa Medical Society
Professional Liability Insurance Program

I'd like to know more about the IMS sponsored program of Liability Insurance designed by Aetna Life & Casualty. I understand this in no way obligates me.

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Write to: Aetna Life & Casualty ☐ Att: Darrel Chapman
Commercial Insurance Dept. ☐ 611 Fifth Avenue
Des Moines, Iowa 50309 ☐ Phone: (515) 244-5145

Who determines what a physician's classification is?

Essentially, this is done by the individual practitioner who by completing the application advises of the nature of his practice. From it can be compiled the normal risk or exposure picture of the applicant. This information is used by Aetna underwriting personnel to determine the rate and class. A physician on the Aetna medical staff reviews each application and verifies the correctness of the classification made by the branch underwriter. If the classification assigned is thought to be incorrect by the applicant, the reasons should be set forth in writing for additional consideration by the Aetna physician.

What am I covered for?

Essentially, you are protected for any claims arising out of your rendering or failing to render professional care. Information on the application relating to your specialty is there primarily for purposes of classifying and rating. The insurance policy issued to each participant has in its insuring agreement the following terminology:

Coverage Agreements: The Company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of *individual professional liability coverage*—injury arising out of the rendering of or failure to render, during the policy period, professional services by the individual insured, or by any person for whose acts or omissions such insured is legally responsible, except as a member of a partnership, performed in the

practice of the individual insured's profession described in the declarations including service by the individual insured as a member of a formal accreditations or similar professional board or committee of a hospital or professional society, *partnership liability coverage*—injury arising out of the rendering of or failure to render, during the policy period, professional services in the practice of the profession described in the declarations by any person for whose acts or omissions the partnership is legally responsible.

Are these rates based on the experience of the Iowa doctor?

The initial or the go-in rates are based (1) on the Aetna experience in Iowa, (2) the Aetna experience in the eight other states which have similar sponsored programs, and (3) some rates for trending purposes that are provided by the industry at large. However, as participation and experience grow in Iowa, the Iowa rates will reflect more and more the Iowa experience. Because of the relatively low number of physicians from which to draw data, we will need to use some industry data in our Iowa rates to reflect future claim frequency and cost. In Connecticut the program insures approximately 3,800 doctors and is in its sixth year. The Connecticut rates are currently based about 95% on Connecticut experience. It should be remembered the program has two dividend features available. If the rates generate more premium dollars than are needed to run the program and pay the claims, then the Iowa physician participant will receive a dividend. This means the rates do truly become Iowa rates.

IMS/AETNA PREMIUMS TO DROP IN 1978

Good news was abundant in the first formal report presented last month by Aetna Life and Casualty to the Iowa Medical Society. The report was summarized for the Medico-Legal Committee on October 19 and presented to the Executive Council on October 20. In approximately six months' operation the IMS/Aetna Professional Liability Insurance Program has enrolled nearly 30 percent of the eligible member physicians.

Moreover, looking ahead, the report revealed a reduction in 1978 premiums by an overall average of 2.7 percent. The exact premium for the

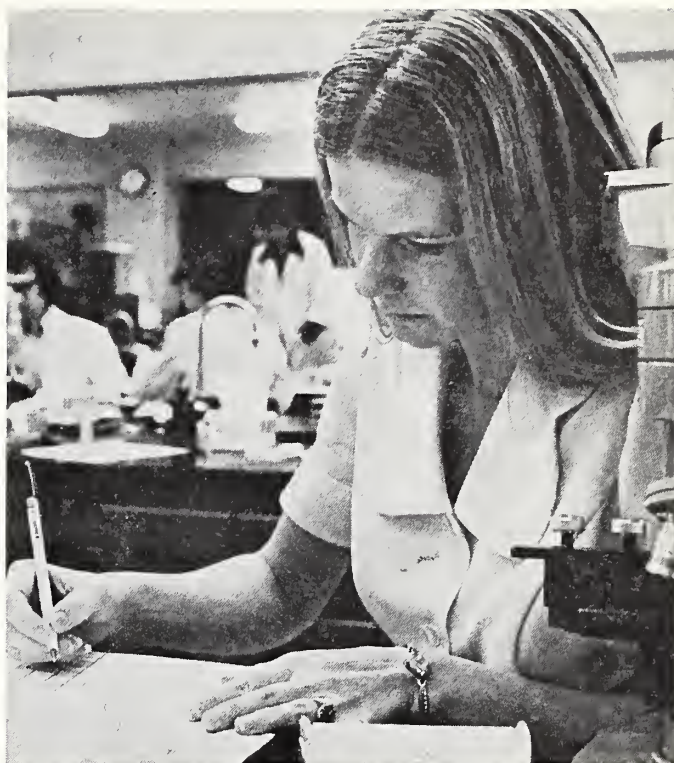
coming year will depend on the classification of the insured physician. In addition, all insured physicians practicing in a partnership will have reduced from 10 to 5 percent the partnership and professional corporation surcharge.

Other points emphasized in the report included (a) an indication that while both frequency and severity of claims continue to increase, there has been a moderation in the rate of increase, and (b) all but one of the other Aetna states (Iowa is the newest of nine such programs) received expense savings dividends this year.

Medical Education Keeps Pace

Production of medical manpower has surged forward in the 1970s. In the campus setting and in the local community, preparation of primary health care personnel has been accelerated. Hard work and innovation are now beginning to pay off. Activity emanating from the University of Iowa is described here.

KEN KOOPMAN
Iowa City



WHEN HEALTH EDUCATORS look back on the 1970s, they are likely to describe them as the most productive and innovative years in the history of health science education. No doubt the most striking statistics will be the marked increase in the numbers and kinds of health professionals completing educational programs. On graduation day in 1967, for example, 7,743 young men and women in the nation donned green academic hoods signifying receipt of the degree of doctor of medicine. By 1976, the number had climbed to 13,470, a figure that probably will be maintained for several more years.

Along with across-the-board expansion in the ranks of the established health professions have come educational programs for entirely new kinds of health professionals, such as physician's assistants and pediatric nurse practitioners. In medical schools curricular patterns considered by students to be inscribed in stone came in for critical faculty review and revision. Some schools made quick and extensive curriculum changes; other schools, such as the University of Iowa College of Medicine, moved cautiously to increase the number of health care students, holding fast to the

tenet that "quality" should never be sacrificed for "quantity" in health education programs.

RESPONDING TO CHALLENGES

The 1970s have seen emergence of a new medical specialty—family practice—with corresponding demise of the term "general practitioner" which for years described the steadily dwindling number of "front-line" physicians. To the surprise of many, large numbers of medical students were eager to become family practitioners if assured their education would equip them thoroughly for what is considered one of the most demanding roles in the profession.

These years also will be recalled by medical educators as a time when "community involvement" by students and their teachers became a substantial part of the total educational process. Communities backed their involvement with service, time, money, professional expertise and graciousness. It has been a time, too, when much effort has gone into the careful study and establishment of model health care delivery systems, with the objective of finding better ways to bring health care to people in an ever-changing society.

New classroom and library facilities were under

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Ken Koopman is Assistant Director of Health Center Information and Communication at The University of Iowa.

MEDICAL EDUCATION

(Continued from page 439)

way at the start of the decade. As a consequence, the College moved toward increasing the number of medical students. In a few years, the entering class size pushed up 45 per cent from 120 to 175 students. The number of graduating physicians climbed 50 per cent from 110 in 1970 to 166 this year, the largest graduating class in the College's history.

New educational opportunities in Iowa following graduation have led to other impressive statistics. In 1970, only eight students or seven per cent of the graduating class, stayed in Iowa for their residency (specialty) training. This year, 68 graduates, or 41 per cent of the class, began their residency training in Iowa. Keys to this turnaround were the establishment of a strong Department of Family Practice in the College of Medicine and the formation of the Statewide Medical Education System.

FAMILY PRACTICE RESIDENCY

The statewide system was created in 1973 by an Act of the Iowa General Assembly, to promote the training of family practice (FP) physicians and to encourage trainees to practice in Iowa. Since then, eight programs have been developed in Cedar Rapids, Davenport, Des Moines, Iowa City, Mason City, Sioux City and Waterloo. The number of physicians in training is 139 this year and will go to 164 next year. This year, 20 (53%) of the physicians completing training in the FP programs selected Iowa practice sites and half of them located in communities with populations of 15,000 or less. Various educational experiences and opportunities for FP specialty training are now encouraging one-fourth of all U. of I. medical graduates to pursue careers as family physicians.

Two programs have been started at the U. of I. to train new kinds of health professionals—pediatric nurse practitioners (PNP's) and physician's assistants (PA's). Since 1972, 80 nurses have been trained for expanded roles in preventive health care and health supervision of children. In the first national PNP certification examination, graduates of the U. of I. program ranked fifth in average score among the 47 institutions with five or more graduates taking the test.

Also started in 1972, the physician's assistant program now prepares PA's to perform—under

physician supervision—many of the tasks traditionally carried out by the physician. Seventy students have completed the 24-month program, and more than two-thirds of them are in varied health service capacities in Iowa. In three national certification examinations, the scores of graduates have placed the U. of I. program second, third, and fourth. A new phase of the program will employ U. of I. staff PA's in the model family practice centers (which are part of the statewide system) in Mason City, Des Moines (Broadlawns Hospital), Davenport and a rural satellite clinic in DeWitt. Among the objectives will be to demonstrate to students the professional role of the PA and to introduce family practice residents to the capabilities and utilization of the PA.

While these programs include many students, they are but a part of the total educational effort of the College of Medicine. Some 3,000 other students in fields such as nursing, pharmacy, dentistry, allied health and liberal arts receive part or all of their instruction in the College of Medicine. On top of this, the Office of Continuing Medical Education annually presents more than 140 formally structured programs for health professionals. These are at the U. of I. and in nearly half of the state's counties. Nearly 7,000 registrations are recorded, 75 per cent of them by Iowans. About 60 per cent of Iowa's medical practitioners participate in the programs and nearly 800 faculty members are involved in instruction. In addition, faculty members each year log some 400 individual presentations to medical, allied health and public audiences in Iowa communities.

UNIVERSITY HOSPITALS

Central to this huge educational endeavor is the University of Iowa Hospitals and Clinics—the nation's largest university-owned teaching hos-

NATION'S 7 LARGEST UNIVERSITY-OWNED
TEACHING HOSPITALS*

	Beds	Admissions
U. of Iowa	1,099	37,181
U. of Michigan	1,050	22,491
U. of Texas	1,025	22,049
Ohio State U.	876	25,278
Virginia Commonwealth U.	848	21,975
Duke U.	833	28,217
U. of Rochester	741	22,207

* Based on 1975 data.

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MEDICAL EDUCATION

(Continued from page 440)

pital—where some 1,800 students receive clinical training each year at all levels of health care, from primary to secondary to tertiary. This year, 506 physicians and dentists are taking specialty training at the Hospitals. Thirty-six per cent of 116 residents who began practice in July chose to remain in Iowa, half in private practice and half in academic staff appointments.

In addition to providing the clinical facilities for training students and residents, most any day will also find practicing health professionals from Iowa and other states updating their knowledge by working alongside faculty members in operating rooms, clinics and many specialized units of the Hospitals. An essential requirement for superior education programs in the health sciences is superior clinical facilities, and these have been developed by University Hospitals through more than three-quarters of a century of service to Iowa patients and to their referring physicians.

Since 1946, the number of admissions to University Hospitals has increased more than 125 per cent to 39,341 the past year. More than 300,000 outpatient visits are recorded, an 81 per cent increase since 1959. While most patients served are Iowans, some 3,000 admissions and 31,000 outpatient visits are recorded by patients who come from other states and even from other nations. The dual education-service role of the Hospitals has been enhanced recently with the completion of a seven-story North Tower Addition to the General Hospital. Next year will see the opening of the new Roy J. Carver Pavilion, named for the Muscatine industrialist who contributed \$2 million toward its construction.

DISPERSED PROGRAMS

Centers that provide primary and secondary care for regions within the state are another educational dimension of the College of Medicine. Two programs have been developed as organizational and operational models to serve as prototypes for other areas in Iowa.

A model community health center has been established in Muscatine, an Iowa community of some 40,000 residents in the urban and rural environs. The Muscatine Center is a group practice that combines primary care specialists—family physicians, internists and pediatricians. While providing health care (some 30,000 patient records

UNIVERSITY OF IOWA HOSPITALS AND CLINICS SERVICE RECORD

	1976-77	1975-76
Bed complement	1,080	1,080
Patient admissions	39,241	38,672
Patient days of care	323,417	329,931
Outpatient clinic visits	309,693	299,592
Births	2,856	2,510
Major surgical operations	14,880	14,854
Special procedures/outpatient surgery	26,510	24,144
Radiographic procedures	179,465	168,336
Laboratory analyses	2,492,545	2,303,755
Pharmacy orders	1,146,438	1,060,244
Meals served	1,628,898	1,529,290
Blood and component transfusions	37,680	36,143
Staff physicians and dentists	315	309
Resident physicians and dentists	400	402
Fellow physicians	82	67
Professional nurses	695	582
Other professional staff	391	340
Other hospital staff	2,113	1,891
Total staff	3,996	3,591

are on file), the Center maximizes the use of PA's in the office, nursing home and emergency room practice. The program serves as a demonstration model for resident physicians training in internal medicine, family practice and pediatrics, as well as PA students. Continuing research is carried out on (1) this "team approach" to the delivery of health services and (2) on the impact the Center makes on the health of the community.

The Model Regional Primary Care Program at Red Oak is intended to demonstrate how a rural area can revitalize its primary medical resources. The model is based on the concept of a group of family physicians working together to serve a central rural community and surrounding small towns. The group practice in Red Oak employs physician extenders and operates a satellite clinic to make primary medical care more accessible to area residents. The College of Medicine provides assistance to other Iowa communities interested in duplicating elements of the Red Oak model.

The activities of The University of Iowa in health education and service have been significant in the 1970's. They are only summarized here. When the health educators review this decade they may note some mistakes—but for the most part they will find any wrong turns were overshadowed by many educational innovations that, in their own way, rival the scientific discoveries which have vastly improved the human condition.

In Iowa Hospitals—What For? How Long?

WHAT HEALTH PROBLEMS among Iowans result most frequently in hospitalization? And what surgical/diagnostic procedures are most frequently performed in Iowa hospitals?

Simply as an informal barometer to help answer these questions, and acknowledging the following listing needs a more elaborate explanation to be completely understood, the JOURNAL nonetheless presents below in a descending order of frequency those inpatient diagnoses reported by Iowa hospitals through what is called the ICDA-8 (International Classification of Diseases, Adapted).

An additional listing is provided which indicates the frequency of the particular services (diagnostic and/or surgical) which have been rendered to the hospital inpatient during the six-month interval involved.

The period covered in both tabulations is six

DIAGNOSIS FREQUENCY

<i>Description</i>	<i>Percent of Diagnoses</i>	<i>Average Length of Stay</i>
Single Born, No Mention of Immaturity	6.99	3.9
Delivery, Without Mention of Complications	5.40	3.9
Symptomatic Heart Disease	2.50	8.3
Diarrheal Disease	2.28	4.2
Tonsils and Adenoids		
Hypertrophy	2.08	2.0
Pneumonia, Unspecified	1.71	7.4
Cholelithiasis	1.48	9.3
Disorders of Menstruation	1.48	3.2
Acute Myocardial Infarction	1.45	13.0
Acute Bronchitis and Bronchiolitis	1.36	5.6
Other Personal Without Complaint/Illness	1.28	2.3
Inguinal Hernia, No Obstruction	1.27	5.6
Diabetes Mellitus	1.23	8.4
Gastritis and Duodenitis	1.06	4.6
Neuroses	1.06	8.3
Acute, Ill Defined		
Cerebrovascular Disease	1.03	12.0
Concussion	1.03	2.7
Tooth Development and Eruption Disorders	1.03	2.1
Alcoholism	0.97	5.6
Acute Appendicitis	0.95	5.9

months (July/December 1976) and is from a compilation of the Health Services Data System of the Iowa Hospital Association. The diagnostic frequency listing covers 103,123 patients discharged from 75 Iowa hospitals. The surgical/diagnostic procedures list was compiled from information on 55,916 patients.

The top 20 of 100 total entries are noted in each instance. In the case of the diagnosis the first 20 constitute about 38% of the total. In the case of procedural frequency about 56% of the total is in the first 20 entries.

PROCEDURE FREQUENCY

<i>Description</i>	<i>Percent of Procedures</i>	<i>Average Length of Stay</i>
Physical Therapy	8.6	10.7
Circumcision	6.3	4.1
Episiotomy	5.6	3.7
Dilation and Curettage of Uterus	3.6	2.5
Intravenous Pyelogram	3.5	5.4
Endoscopy of Colon and Rectum Without Effect Upon Tissue or Lesion	3.1	6.2
Tonsillectomy With Adenoidectomy	2.6	1.9
Repair Inguinal Hernia, Not Recurrent	2.3	5.8
Cholecystectomy	2.2	11.4
Surgical Removal of Tooth	2.1	2.9
Radioisotope Examination	2.1	8.2
Appendectomy	1.9	6.1
Bilateral Ligation and Division of Fallopian Tubes	1.9	3.0
Cystoscopy and Urethros-copy Without Effect Upon Tissue or Lesion	1.8	5.5
Low Forceps Delivery With Episiotomy	1.7	4.4
Abdominal Hysterectomy, Complete or Total	1.6	8.9
Traction and External Fixation Device Without Manipulation for Reduction	1.6	9.4
Suture of Skin or Mucous Membrane	1.6	4.0
Local Excision of Lesion of Skin and Subcutaneous Tissue	1.3	7.1
Other Physical Medicine and Rehabilitation Programs	1.2	8.2

IOWA Medical Miscellany

HMO CASUALTY . . . Rural Health Services, Iowa's only health maintenance organization to date, will terminate its operations December 31. Cost overruns during the two-year history of the program are cited as a main reason for the demise. Membership in the HMO was authorized originally for Davis County residents and patients of the county's physicians residing elsewhere. The RHS membership had declined from a 4,000 peak to 3,416. RHS participants are being given the option of enrolling in an alternate Blue Cross/Blue Shield coverage.

NHI HEARING . . . Newton was the site of an October 11 hearing on national health insurance. One in a series of HEW hearings, the Newton session attracted a variety of persons both for and against NHI. The IMS filed a statement to be entered into the Newton hearing record. Several Jasper County physicians appeared additionally to present views following a format which provided for one-on-one interviews between HEW officials and interested persons. Numerous insurance representatives participated.

DIVIDENDS . . . \$3,543 in dividends have been distributed to IMS members who participate in the Workers' Compensation Savings Plan offered by the Dodson Insurance Group through the Iowa Medical Society. Now going into its fourth year, the Plan afforded its highest return to date in 1977—37% of premium. Inquiries regarding the program should be directed to IMS Headquarters.

HEALTH PLANNING . . . Proposed HEW guidelines issued in September indicate Iowa may have to eliminate 6,000 hospital beds by 1983. A ratio of 3.7 beds per 1,000 population is to be achieved over the next five years. Iowa currently has a ratio of 5.7 beds per 1,000 persons with around 16,200 total hospital beds. Hospital occupancy should average at least 80 per cent under the proposed HEW mandates.

IOWAN ELECTED . . . Frederick C. Blodi, M.D., professor and head of the Department of Ophthalmology at The University of Iowa, has been named president-elect of the American Academy of Ophthalmology and Otolaryngology. Dr. Blodi has been on the U. of I. faculty since 1952 and head of ophthalmology since 1967. In a related action, C. M. Kos, M.D., Iowa City, was named executive vice president for otolaryngology.

MEMBERSHIP PEAK . . . Checking Society statistics back to 1950, indications are that 1977 (with 2,614 member physicians) is a record membership year. Next largest membership in the 27-year period was 1956 with 2,515.

STATEMENTS MAILED . . . IMS dues statements for 1978 will go into the mail in late November. As an administrative service, the IMS now bills, collects and disperses annual dues for 84 of the 93 county medical societies in Iowa.

SECOND OPINION . . . Experimentation with a program to require a second surgical opinion for Medicaid patients, authorized by the 1977 Iowa General Assembly, has been disallowed by HEW officials, according to reports heard by the IMS. The matter remains under evaluation.

CONCERN EXPRESSED . . . State Department of Social Services officials are concerned over potential provider reaction to HEW regulations requiring structural modifications in hospitals, clinics, offices, etc., to accommodate the elderly, disabled and blind. Physicians reportedly have until 1980 to meet the requirements.

ANNUAL REPORT . . . Aetna officials presented favorable information in an Annual Report on the IMS/Aetna Liability Insurance Program delivered to the Medico-Legal Committee (October 19) and the IMS Executive Council (October 20). A further discussion of the program appears on Page 436.

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- three dosage strengths meet most patient needs

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psycho-

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tropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relation-

ship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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Please see preceding page for a summary of product information.

Educationally Speaking



by R. M. CAPLAN, M.D.

A READER SPEAKS UP. WON'T YOU?

From time to time I receive an encouraging word from Dr. Bill Catalona of Muscatine. He is one of the few who have accepted my occasional challenge to the reader to let me know his thoughts. He took occasion to empty himself of some words that I think are worth sharing with you. And after you consider his message, read on for my invitation.

I accept your invitation to respond to the piece on "Continuing Medical Education." "A feeling of a personal need," "How to proceed with learning strategies," and especially, "Identifying my own needs," have plagued me for many years. Certainly reading and listening to tapes is not enough, and going to medical meetings alone is not enough. As I look back on my many years of learning, I think I've had to learn a number of things over and over.

As to methods of identifying needs for learning, in my experience it has been the regularly occurring, puzzling patient problem situations that prompted me to stop and say, "I don't know what is going on here; I'd better take time out and learn." Consider the immediacy of this need; it does not allow for the attendance at an appropriate continuing medical education course. Add to these regularly occurring, puzzling questions the basic desire of most doctors to have some knowledge in areas relating not only to providing quality health service, but to understanding physiology and pathology as well.

Continuing medical education has to be a lifetime of learning. I suppose the bureaucratic requirement of certain hours of continuing medical education will expose all of us to more knowledge,

but I don't think it will answer the questions you have asked.

I'm sure you've gone to a medical meeting and looked at the program and, where there are a variety of sessions going on at the same time, asked yourself, "Shall I go hear this paper, see this slide program or this film?" It's not easy to identify one's needs except from recognizing his deficiencies.

Finally, I know there are many doctors who are eager to continue their medical education and provide good service for their patients. They have done it in spite of not attending organized continuing medical education programs, and this has to be a tribute to their dedication and desire to provide quality care.

Bill was not looking to be published in this space, but what he had to say deserves it. Have you something on your mind that you'd like to express to the rest of us? Be my guest! Send me those thoughts, and I'll be delighted to share this space so that your point of view can be told. I hope you will!

PNEUMONIA STUDY . . . A statewide study of primary bacterial pneumonia is now in process under direction of the Continuing Medical Education Committee of the Iowa Foundation for Medical Care. Information on the study has been sent to all hospital chiefs of staff.

PSRO PROGRESS . . . The Iowa Foundation for Medical Care now has approved 73 Iowa hospitals for PSRO delegated status. It is expected the IFMC will have all 135 of the state's hospitals under some level of PSRO review shortly after the first of the year.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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Therapeutic Index, Jan.-Dec., 1976. IMS America
List of Drugs, A.M.A. Drug Evaluations, 2nd ed.
22-3.

mg: Pseudoephedrine
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receiving

may be habit forming. Abuse may be characterized by severe withdrawal symptoms. Severe withdrawal symptoms may include severe depression, fatigue, anorexia, weight loss, and insomnia. Severe withdrawal symptoms may be relieved by the use of antidepressants. Severe withdrawal symptoms may be relieved by the use of antidepressants. Severe withdrawal symptoms may be relieved by the use of antidepressants.

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References:
1. American Medical Association, "Drug Facts and Comparisons," 1973, pp. 482-3.
2. American Medical Association, "Drug Facts and Comparisons," 1976, IMS America Ltd., Ambler, Pa., 2nd Edition, Publishing Science.

NF 100 mg; Pseudoephedrine Hydrochloride Syrup, 1.4 per cent. CONTRAINDICATIONS:
• Patients who are receiving MAO inhibitors or who are taking another drug with a high blood pressure effect should be administered with caution. Patients with high blood pressure should be administered with caution. Patients with high blood pressure should be administered with caution.

References:
National D
er. M

Pseudoephedrine HCl, NF.
Effectively effective nasal/sinus decongestant.
Gives congestion, reduces edema, promotes drainage.
mg pseudoephedrine in a 2-teaspoonful adult dose.

You prescribe the quantity dispensed available in pints only.

References:
*National Disease & Therapeutic Index, Jan-Dec., 1976. IMS America Ltd., Ambler, Pa. 1976.
†Amer. Med. Assn., Dept. of Drugs, A.M.A. Drug Evaluations, 2nd Edition, Publishing Science
Acton, Mass., 1973, pp. 482-3.

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patients with high blood pressure, he
should be administered
prostatic hypertrophy
with this product should produce a
drowsiness, dizziness or sle
acid (5-HIAA) are
palpitations

References:
National Disease & Therapeutic Index
† Amer. Med. Assn., Dept. of Drugs,
Acton, Mass., 1973, pp. 482-3.

[illegible]

FREE OFFER—For a 1978 calendar featuring a poster-size, full-color reproduction of this photo of Southern Railway Engine No. 630, write "**Robitussin-DAC**" on your Rx pad and mail to "Train Offer," A. H. Robins Company, 1407 Sherwood Avenue, Richmond, VA 23220.

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The New Iowa Immunization Law

Iowa youngsters must be immunized beginning in 1978 if they are to be admitted to school. The requirements of the new immunization law are summarized here. Understanding of health providers is important.

THE NEW IOWA LAW requiring administration of immunization against certain communicable diseases is now in process of implementation. As a result of enactment by the 1977 General Assembly, Iowa joins a majority of states with statutes making compulsory the acquisition of certain vaccinations as a condition for acceptance into school.

The law was to have become effective this Fall but the limited preparatory time necessitated a delay in implementation. The statute requires all parents or guardians to assure and certify their children have been immunized against diphtheria, tetanus, pertussis, poliomyelitis, rubella and measles. By January 1, 1978, these immunizations must be certified if admission to licensed child-care centers is to be achieved. For public or non-public elementary or secondary schools in Iowa the certification deadline corresponds with the beginning of the second semester of the 1977-78 school year.

Each enrollee must submit to the admitting official (meaning superintendent of schools or his/her designee) either (1) a Certificate of Immunization, or (2) a Provisional Certificate of Immunization, or (3) a Certificate of Immunization Exemption. The latter exemption is allowed for either medical or religious reasons. Both types of exemption may be specified on the same certificate.

According to the rules, which are not finally approved as this is written, a medical exemption may be granted when, in the physician's opinion, the required immunizations would be injurious to the health and well-being of the applicant or any member of the applicant's family or household. A medical exemption may apply to any or

all of the required immunizations. A waiver to a specific vaccine due to an age restriction or medical contraindication shall be indicated on the certificate of immunization. A certificate of immunization exemption is valid only when signed by a doctor. If, in the opinion of the doctor issuing the medical exemption, the exemption should be terminated or reviewed at a future date, a reference to that fact should be made.

A set of procedures has been devised to implement the religious exemption. This phase of the law does not involve the physician directly. However, the right is reserved to void religious exemptions in time of emergency.

The process of validating the appropriate certificate will involve the physician in making a

IMMUNIZATION CONFERENCE

The new Iowa immunization law will be reviewed at a conference on Wednesday, November 16 at the Iowa Medical Society Headquarters. The meeting will begin at 1:15 p.m. and is sponsored by the IMS and the Iowa State Department of Health.

The informational meeting is open to physicians, their staff, and others concerned with the implementation of the law.

comparison between the law's requirements and the child's immunization history. The information may be obtained from records in the physician's office or from information or records supplied by the parent or guardian. It will be necessary for the physician to exercise personal judgment in assessing dates, types and sources of immunizations presented by parents, if they have been obtained elsewhere. It is noteworthy that the physician is not held responsible for the accuracy of information when he or she validates either a Certificate or a Provisional Certificate of Immunization if they are based on records other than their own. In this event the signature of the physician validates the fact that a record of immuni-

zation history has been presented by a parent or guardian.

The following comment from an October communication from State Health Commissioner Norman Pawlewski to Iowa physicians is significant in terms of administration:

In order that an effective, yet practical and equitable, distribution of the up-coming workload be realized in implementing the law a Certificate of Immunization or a Provisional Certificate of Immunization may also be validated by the following health professionals: (1) physician's assistants, (2) nurse practitioners, (3) county public health nurses, (4) school nurses, and (5) officials of local health departments. In addition, your (the physician's) office nurse may sign your name upon your direction if you so desire. Your signature should be placed on the "signature of health official" line.

The PCI is to be used in two instances: (1) with transfer students, and (2) with students who have not yet received all required immunizations, but have had at least one dose of each of the required vaccines (DTP- or pediatric DT or adult Td as circumstances warrant—polio, rubella and measles). In those cases where no immunizations have been given it is both safe and effective, according to the State Department of Health, to immunize the person with one dose of each of the required vaccines at one visit.

A PCI expires 120 days after validation, or at the end of the semester in which the individual is enrolled, whichever period is longer. The PCI must list the remaining immunizations which are needed and the expiration date. The child must acquire the remaining immunizations during the provisional period. If he/she does not obtain the vaccinations by the end of the period the child must be excluded from school. Provisional enrollment may be extended if the child becomes sick during the provisional period and the immunizations must be delayed of medical necessity. In such a situation another PCI may be submitted or a brief explanation may be entered on the original certificate stating that an extension is necessary. Once the required immunizations are obtained the PCI can be replaced by a CI. It is not necessary to obtain a new CI each year.

The most concentrated effort in implementing the law will occur over the next few months. In subsequent years the primary concern will be for kindergarteners and transfer students.

REQUIRED IMMUNIZATIONS

Age	Immunizations
0-2 months	None required.
2-18 months	At least one dose of combined diphtheria, tetanus and pertussis vaccine. Pediatric diphtheria and tetanus may be substituted when pertussis is contraindicated. At least one dose of trivalent oral polio vaccine. Special requirements for receiving inactivated Salk vaccine are available upon request from the Iowa State Department of Health.
1½-4 years	At least three doses of DPT vaccine. Adult tetanus and diphtheria vaccine or pediatric diphtheria and tetanus vaccine may be substituted for combined DPT when a child is six years or older or when pertussis vaccine is contraindicated. At least three doses of trivalent oral polio vaccine. Special requirements prevail as noted above. At least one dose of measles vaccine after the applicant was at least 12 months of age. After 1/1/77 applicants shall be at least 15 months of age. At least one dose of rubella vaccine received after applicant is at least 12 months of age. After 1/1/77 applicants shall be at least 15 months of age.
4 years plus	At least three doses of DPT. At least one dose of combined vaccine shall have been received after the applicant's fourth birthday. Applicants 6 years of age and older are exempt from receiving further doses of pertussis vaccine. Adult tetanus and diphtheria or pediatric diphtheria and tetanus vaccine should be substituted for combined DPT vaccine when a child is six or older or when pertussis vaccine is contraindicated. At least three doses of trivalent oral polio vaccine. At least one dose of TOPV shall have been received after the applicant's fourth birthday. Applicants 19 years of age and older are exempt from polio requirements. Special requirements for applicants receiving inactivated Salk vaccine are available on request from the SDH. At least one dose of rubella vaccine or demonstrate a positive hemagglutination antibody titer to rubella. Applicants receiving the vaccine shall have been at least 12 months of age at the time of immunization. Female applicants 12 or older and menstruating females less than 12 are exempt from the rubella immunization requirement. At least one dose of rubeola (measles) vaccine after 1/1/65. Applicants shall have been at least 12 months of age at time of immunization; after 1/1/77 they shall be at least 15 months of age. This requirement shall be waived for applicants with a history of measles illness diagnosed by a doctor. Female applicants 12 or older and menstruating females less than 12 are exempt from the measles immunization requirement.

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State Department of Health

LEGIONNAIRES' DISEASE: DIAGNOSIS, ETIOLOGY, PATHOLOGY, & THERAPY

Although much is still to be learned, enough is known about the Legionnaires' disease and its etiologic agent that a preliminary composite of the salient features of the disease, its course, and approach to the diagnosis and therapy can be formulated. Evidence suggests the same bacterium which caused the 1976 outbreak of pneumonia in Philadelphia also caused outbreaks in the District of Columbia in 1965, in Pontiac, Michigan in 1968, and in Philadelphia in 1974. Since August 1976, over 20 sporadic cases of pneumonia associated with the same bacterium have been identified from 11 states. Of these sporadic cases, the diagnosis in two was first made by isolating the organism on bacteriologic medium; in a third case, the isolation of the agent was made by inoculating postmortem lung tissue into a guinea pig; the remaining cases were diagnosed by demonstrating significant rises in titer in paired sera. Clearly, the disease is neither localized nor new.

Clinical Findings: Legionnaires' disease begins 2 to 10 days after exposure. In the typical case, the earliest symptoms are malaise, muscle aches, and a slight headache. Within less than a day, there is a rapidly rising fever associated with chills. A nonproductive cough is common early, often with the onset of initial symptoms. Abdominal pain and gastrointestinal symptoms also occur in many of the patients. Temperatures commonly reach 102 to 105 F (39-41 C). When first examined by a physician, most patients have been found to have rales without evidence of consolidation. The rest of the findings on physical examination are usually normal, although some patients have been obtunded. Initial laboratory findings often include a leukocytosis (in 60%) with a left shift, 3+ proteinuria or greater (in 20%), erythrocyte sedimentation rate greater than 80

mm per hour (in 33%), and, in a significant minority, hyponatremia, mild azotemia, and elevation of the serum glutamic oxaloacetic transaminase (SGOT) and alkaline phosphatase. Chest x-rays show patchy, interstitial infiltrates or areas of consolidation which progress to more widespread consolidation. Effusions, when present, are usually minimal.

Illness usually progresses over the 2 to 3 days after hospitalization. Cough commonly becomes productive, but the sputum is rarely purulent. Approximately 15% of the patients die, either of shock or respiratory failure. Upper and lower gastrointestinal bleeding is not uncommon, but may be related to the stress of illness. Renal failure has been seen in several patients. In those who recover, the radiographic evidence of improvement lags a few days behind clinical resolution.

Chemotherapy: No randomized trial of antibiotic therapy has been performed. Of the drugs used, cephalothin has been associated with a relatively high case-fatality ratio, and erythromycin and tetracycline with relatively low case-fatality ratios. These associations with case-fatality ratios, however, may be as much a reflection of the physician's assessment of the severity of illness as they are indications of the efficacy of drug treatment. Agar dilution susceptibility testing has shown the organism to be "susceptible" or "moderately susceptible" to a large number and a wide variety of antibiotics. In general, erythromycin, a number of penicillins, cephalosporins, aminoglycosides, chloramphenicol, rifampin, and sulfamethoxazole-trimethoprim produce *in vitro* results in the "susceptible range"; tetracycline and methicillin minimum inhibitory concentrations (MIC) were borderline, and vancomycin MIC suggested resistance. The *in vitro* interpretations do not always correlate with *in vivo* response. Tests in embryonated eggs showed rifampin, gentamicin, streptomycin, and erythromycin to be most ef-

(Please turn to page 454)

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Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); and 25 mg phenobarbital in the immediate release layer.

Each 5 ml teaspoonful contains 32.5 mg theophylline, 6 mg ephedrine HCl, and 2 mg phenobarbital; the alcohol content is 15%.

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These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

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Warnings. Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING.

Precautions. Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions. Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

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Tedral: *Adults*—One or two tablets every 4 hours. *Children*—(Over 60 lb) one-half the adult dose.

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Supplied. Tedral: White, uncoated scored tablets in bottles of 24 (N 0047-0230-24), 100 (N 0047-0230-51) and 1000 (N 0047-0230-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0230-11).

Tedral SA: Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in Unit Dose—package of 10 x 10 strips (N 0047-0231-11).

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Full information is available on request.

Morbidity Report for September 1977

Disease	Sept. 1977	1977 to Date	1976 to Date	Most September Cases Reported From These Counties
Amebiasis	18	95	34	Boone
Brucellosis	5	15	14	Decatur
Chickenpox	87	7461	9047	Scattered
Conjunctivitis	68	1819	1535	Scattered
Encephalitis, unspecified	3	6	2	Scattered
Erythema infectiosum	2	53	162	Chickasaw
nodosum	1	1	—	Winneshiek
Gastrointestinal viral inf.	1458	17838	17318	Scattered
Giardiasis	6	65	24	Boone
Guillian Barre syn.	1	3	—	Buena Vista
Hepatitis infectious	15	88	96	Polk, Scott
serum	5	95	63	Dubuque, Linn
unspecified	3	31	17	Polk
Histoplasmosis	1	2	14	Scott
Impetigo	113	534	580	Johnson, Pottawattamie
Infectious mononucleosis	85	811	782	Linn, Polk
Influenza-like illness	2333	42818	39,255	Scattered
Meningitis aseptic	1	13	11	Johnson
unspecified	3	15	4	Johnson
Mucocutaneous lymph node	1	1	—	Story
Mumps	6	1187	1245	Scattered
Pediculosis	66	309	361	Pottawattamie
Pertussis	2	4	6	Delaware, Dubuque
Pinworms	2	31	30	Polk
Pneumonia	72	726	767	Scattered
Rabies in animals	15	101	106	Scattered
Rheumatic fever	1	27	17	Carroll
Rhinovirus	1	1	—	Lyon
Ringworm, body	46	232	195	Scattered
Rubella	6	167	87	Scattered
Rubeola	10	4275	37	Mills
Salmonellosis	52	206	97	Scattered
Scabies	123	719	479	Emmet
Shigellosis	3	37	66	Polk
Streptococcal infections	560	9550	11625	Scattered
Trichuriasis	1	3	13	Johnson
Tuberculosis total	3	72	85	Polk, Story, Warren
b.p.	2	59	74	Story, Warren
Venereal diseases gonorrhea	584	4435	5037	Polk
P. & S. syphilis	2	30	—	Dubuque, Muscatine
syphilis (other)	16	224	252	Muscatine, Pottawattamie

Laboratory Virus Diagnosis Without Specified Clinical Syndrome
Adenovirus—1, Coxsackie B5—1, Cytomegalovirus—2, Eaton's agent infection—10, and Herpes simplex—5.

STATE DEPARTMENT OF HEALTH

(Continued from page 451)

fective in that order. Erythromycin has been effective against experimental infection in guinea pigs. Similar studies with other antibiotics are under way. At present, it is impossible to say what is the best antibiotic to use in treating patients with Legionnaires' disease, but erythromycin appears to be a promising agent.

Pathology: In fatal human cases, the pneumonia caused by the Legionnaires' disease organism has been of the lobar type. Since we have not had the opportunity to examine lung biopsy tissues from patients surviving the disease, we cannot characterize early lesions or milder manifestations of the disease. In paraffin sections the organism stains poorly with tissue gram stains (i.e. Brown-Brenn and Brown-Hopps stains) and the giemsa stain. It does not stain at all with hematoxylin and eosin, acid fast, gimenez, and methenamine silver stains. In our experience the dieterle silver impregnation procedure consistently demonstrates the organism in paraffin-embedded sections. The largest number of organisms is associated with intraalveolar proteinaceous debris and infiltrates of polymorphonuclear neutrophils and macrophages.

Isolation and Identification of the Etiologic Agent: The initial isolations of the bacterium of Legionnaires' disease were made in guinea pigs inoculated with lung tissues obtained portmortem from 4 patients. The guinea pigs developed a febrile illness characterized by watery eyes and prostration 1 to 2 days after inoculation. Moribund animals were sacrificed 3 to 6 days after onset of fever, and specimens from the spleen, liver, and lungs were inoculated into 7-day-old embryonated hens' eggs. The eggs died 4 to 6 days after inoculation, and smears of yolk sacs stained by the gimenez method showed bacilli 0.3-0.4 μm in width and of various lengths. The etiologic role of the bacterium was established by indirect fluorescent antibody (IFA) tests with appropriate sera from patients with Legionnaires' disease.

Gram Stain shows the organisms to be gram negative rods, approximately 0.5 x 0.7 μm wide, and 2 to 3 μm in length. The length, however, is variable and rods up to 20 μm or longer have been observed. The longer forms are frequently curved and vacuolated. Primary isolation of the organism on bacteriologic media is a sophisticated proce-

dures and is not discussed here. Specific advice and assistance in these procedures are available from the State Hygienic Laboratory in Iowa City.

Serologic Diagnosis: The IFA test, with suspected acute and convalescent paired sera and a freshly thawed yolk sac suspension of the Legionnaires' organism as antigen, currently remains the test of choice. Other tests, including microagglutination and complement fixation, are being evaluated, but none has achieved the level of sensitivity or specificity of the IFA test.

At this time, the serologic procedures appear to be the most important laboratory tools for the diagnosis of Legionnaires' disease. Efforts are underway to develop a sensitive, yet practical, serologic test which could be made readily available to all serology laboratories. Until such a test is available, paired serum specimens should be submitted through the Iowa State Hygienic Laboratory to the Center for Disease Control, and must be accompanied with a summary of the patient's clinical history, including dates of onset and dates specimens were taken. Diagnostic titers may appear in sera obtained as early as the second week of illness, but the greatest proportion of diagnostic titers has occurred in sera obtained 22 to 60 days after the onset of illness. Thus, the acute serum specimen should be obtained as early as possible, and the convalescent specimens should include one taken after the third week.

In order to provide the best possible assistance, consultation, and support in the epidemiologic and laboratory investigation of suspect cases of Legionnaires' disease, medical care personnel are encouraged to contact the appropriate state health officials for preliminary consultation and referral to the Center for Disease Control. Such requests should be channeled as follows:

A. *Epidemiology and Management of Patients*

Laverne A. Wintermeyer, M.D.
Director of Infectious Disease Control
and State Epidemiologist
Iowa State Department of Health
Des Moines, Iowa 50319
Tel. 515-281-5424

B. *Laboratory and Diagnostic Studies*

W. J. Hausler, Jr., Ph.D., Director
State Hygienic Laboratory
University of Iowa
Medical Laboratories Building
Iowa City, Iowa 52240
Tel. 319-353-5990

About IOWA Physicians

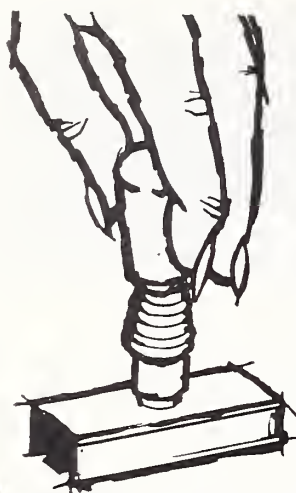
Dr. Steve Krogh, family practitioner, and **Dr. Jon Fusselman**, pediatrician, have joined the Muscatine Community Health Center. Dr. Krogh received the M.D. degree at the U. of I. and completed his family practice residency at Broadlawns Hospital in Des Moines. Dr. Fusselman received the M.D. degree at the University of Nebraska and completed his pediatric residency at North Carolina Memorial Hospital in Chapel Hill, North Carolina. . . . **Dr. Mitchell C. Ruffcorn** has joined **Drs. Victor Edwards** and **Larry Rigler** at Medical Associates in Iowa City. Dr. Ruffcorn received the M.D. degree at the U. of I. and completed his family practice residency at University Hospitals. . . . **Dr. Ken M. Johannsen**, surgeon, joined the Buena Vista Clinic in Storm Lake in August. Dr. Johannsen received the M.D. degree at University of Nebraska and completed his surgical residency at VA Hospital in Des Moines. Dr. Johannsen was in family practice in Spencer from 1966 to 1973. Dr. Johannsen is a past chief of staff of Spencer Municipal Hospital and a past president of the Clay County Medical Society.

Dr. Cornelius Maris recently completed 50 years of medical service to Sanborn and the surrounding communities. Dr. Maris received the M.D. degree at the U. of I. and interned at University Hospital. He began general practice with his uncle, Dr. William Maris in Sioux Center, and moved to Sanborn in 1929. . . . **Dr. John C. VanGilder**, professor and chairman of the U. of I. Department of Neurosurgery, has been named to the Society of Neurological Surgeons. . . . Beginning October 1, **Dr. Walter M. Block**, Cedar Rapids, will limit his practice to behavior, learning and developmental problems of infants, children and adolescents. **Dr. Richard L. Zeaske** will assume his general pediatric practice. . . . **Dr. William E. Anderson, Jr.**, began a solo practice of internal medicine in Burlington in August. Dr. Anderson received the M.D. degree at the U. of I. and served his resi-

dency at the Mayo Clinic in Rochester, Minnesota. . . . **Dr. Jack Fickel**, Red Oak, chaired a workshop session on health facilities and services at a recent conference in St. Joseph, Missouri. . . . **Dr. Richard G. Asarch** has opened an office in Des Moines to practice dermatology and dermatologic surgery. Dr. Asarch received the M.D. degree at U. of I. College of Medicine.

Dr. Robert W. Ruess, surgeon, recently joined **Dr. Kenneth H. McKay** in Davenport. Dr. Ruess received the M.D. degree at the University of California, Irvine. He interned at U. S. Naval Hospital in Jacksonville, Florida and had his surgical residency at University Hospitals in Iowa City. . . . **Dr. Thomas R. Gilman**, D.O., has joined the Department of Obstetrics and Gynecology and **Dr. Richard L. Colley** the Department of Allergy at the North Iowa Medical Center in Mason City. Dr. Gilman received the D.O. degree at the College of Osteopathic Medicine and Surgery in Des Moines; interned at St. Joseph's Hospital in Syracuse, New York and had his residency in obstetrics and gynecology at State University of New York, Upstate Medical Center. Dr. Colley received the M.D. degree at Albany Medical College in New York; completed his internship and pediatric residency at Albany Medical Center, and his allergy residency at the National Asthma Center in Denver, Colorado. . . . **Dr. Walter M. Block**, Cedar Rapids, recently addressed a group of teachers and school administrators in Webster City. Dr. Block's topic, "Discipline in the Classroom." . . . **Dr. Donald E. Boyle**, Sioux City, has been appointed by Governor Robert Ray to the Governor's Emergency Medical Services Advisory Council.

Three physicians, **Dr. Ralph T. Duddles**, **Dr. Clem J. Mattson** and **Dr. Charles E. Brady**, have recently joined the Student Health Service at Iowa State University. Dr. Duddles received the M.D. degree at the University of Minnesota. Prior



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to joining the ISU staff, he was associated with the University of Colorado Student Health Service. Dr. Mattson received the M.D. degree at University of Wisconsin and has been in family practice in Sandwich, Illinois since 1971. Dr. Brady received the M.D. degree at Duke University and was formerly associated with the University of Tennessee Memorial Hospital and Research Center in Knoxville, Tennessee. He is the sports medicine physician at the Student Health Service and also ISU team physician. . . . **Dr. Ivan Klimsa**, ophthalmologist, recently opened an office in Waterloo. Dr. Klimsa completed his specialty training at City University Hospitals in New York City. He has practiced for three years at the North Point Medical Group in Milwaukee, Wisconsin. . . . **Dr. John Ely** recently joined the staff at McCrary-Rost Clinic in Lake City. Dr. Ely received the M.D. degree at State University of New York, Upstate Medical Center in Syracuse and completed his family practice residency at the University of Washington in Seattle. . . . **Dr. Eugene L. Kerns** has joined **Drs. Donald J. Heming** and **Harold L. Mihm** to practice obstetrics and gynecology in Davenport. Dr. Kerns received the M.D. degree at the U. of I. and completed his residency at University Hospitals.

Dr. B. Betty Choe recently began the practice of pediatrics in Ottumwa. Dr. Choe received the M.D. degree at Ewha Women's University Medical School in Seoul, South Korea; interned at Augustana Hospital in Chicago and completed pediatric residencies at St. Francis Hospital in Peoria, Illinois and Children's Hospital in Chicago. . . . **Dr. W. H. Verduyn**, Reinbeck, was guest speaker at a recent meeting of the Waterloo Area Ostomy Chapter. Dr. Verduyn spoke on "Sexuality and the Ostomate." . . . **Dr. Kenneth W. Caldwell**, former Montezuma physician, has been named director of student health at the University of Northern Iowa in Cedar Falls. . . . **Dr. Vincent G. Canganelli**, formerly of Floral Park, New York, has opened an office in Winneshiek County Memorial Hospital for the practice of psychiatry. Dr. Canganelli will also serve on the staff of the Northeast Iowa Mental Health Center. . . . **Dr. Robert B. Nieland** recently began a family practice in Monticello. Dr. Nieland received the M.D. degree at U. of I. College of Medicine. Prior to locating in Monticello, Dr. Nieland practiced in Hickory, North Carolina. . . . New officers of the Iowa Dermatological Society are **Dr. James E.**

ten Broeke, Iowa City, president; **Dr. Lynn Glesne**, Mason City, vice president; and **Dr. Roger Ceilley**, Iowa City, secretary-treasurer.

Dr. Lynn A. Glesne and **Dr. Wayne E. Janda** have joined the Park Clinic staff in Mason City. Dr. Glesne is in the Department of Dermatology and Dr. Janda is in the Department of Orthopedics. Dr. Glesne received the M.D. degree and interned at U. of I. College of Medicine. She served residencies at University Hospitals and the University of Pennsylvania. For the past year, she has practiced in Alexandria, Minnesota. Her husband, **Dr. Robert Glesne**, is a urologist with Surgical Associates in Mason City. Dr. Janda received the M.D. degree at University of Chicago. He interned at Milwaukee County Hospital and served orthopedic residencies at Mayo Clinic and Children's Hospital in Chicago. Prior to locating in Mason City, Dr. Janda practiced in San Luis Obispo and Sonoma, California. . . . **Drs. J. T. Baller, Michael Chandra, Don Boyle** and **William Blankenship** were program participants at a recent fall seminar sponsored by the Siouxlend Chapter of the American Association of Medical Assistants. . . . **Dr. Mary S. Peraud**, Fredericksburg, was guest speaker at recent meeting of Chickasaw County Republican Women's Club. Dr. Peraud discussed preventive medicine. . . . New officers for the Iowa Academy of Family Physicians are **Dr. Roger W. Boulden**, Lenox, president; **Dr. Leslie Weber, Jr.**, Wapello, president-elect; **Dr. Gene E. Michel**, Cherokee, vice-president; **Dr. George Kerns**, Des Moines, secretary-treasurer; **Dr. John Hornberger**, Manning, and **Dr. Mervin McClenahan**, Sigourney, board directors; and **Dr. Verne Schlaser**, Des Moines, and **Dr. Charles Beckman**, Kalona, delegates to the American Academy of Family Physicians.

At annual meeting of the Iowa Academy of Ophthalmology, **Dr. Russell H. Watt**, Marshalltown, was installed as president; **Dr. William B. Hofmann**, Davenport, was chosen president-elect; **Dr. Leo J. Plummer**, Des Moines, vice-president; and **Dr. William E. Scott**, Iowa City, secretary-treasurer. . . . **Dr. Roy Wanamaker**, Hamburg, was recently honored for his 50 years of medical service to the community. . . . **Dr. Peter J. Reiter** and **Dr. William G. Heeringa** have joined the Ottumwa Medical Clinic. Dr. Reiter received the M.D. degree at the U. of I. College of Medicine and had his residency in internal medicine at

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University Hospitals. Dr. Heeringa received the M.D. degree at the University of Michigan Medical School, Ann Arbor, and had his residency in internal medicine and a gastroenterology fellowship at University Hospitals in Iowa City. . . .
Dr. Frank Richmond, Jr., Fort Madison, has been named 1978 North Lee County Cancer Crusade Chairman.

DEATHS


Dr. Frank F. McKean, 65, longtime Allison physician, died August 20 at the Allison Manor Nursing Home. Dr. McKean received the M.D. degree at the University of Minnesota. He began his medical practice in Allison in 1941. Dr. McKean was a recipient of the team doctor award presented by the Iowa High School Athletic Association; fellow of the American Academy of Family Physicians and life member of the Academy of General Practice.

Dr. George E. Schnug, 93, longtime Dows physician, died at the Dows Care Center on September

3. Dr. Schnug received the M.D. degree at the U. of I. College of Medicine in 1910 and began his practice in Dows in 1911. He was a charter member of the Lions Club and a life member of the Iowa Medical Society.

Dr. Robert E. Votteler, 56, Marshalltown, died September 12 in Ontario, Canada. Dr. Votteler received the M.D. degree at U. of I. College of Medicine. He was a psychiatrist in association with Dr. Henry Kosieradzki and was also employed by the Mental Health Center for Marshall, Tama and Hardin Counties and by the Iowa State Training School for Boys in Eldora. Dr. Votteler was a member of Iowa Psychiatric Society, American Psychiatric Association and the Iowa Mountaineers.

Dr. Thomas H. VanCamp, 89, longtime Breda physician, died September 7 in Colorado Springs, Colorado. Dr. VanCamp received the M.D. degree at U. of I. College of Medicine in 1917 and interned at Peter Bent Brigham Hospital in Boston, Massachusetts. In honor of Dr. VanCamp, the family has established a memorial to the St. Anthony Regional Hospital library in Carroll, Iowa. Dr. VanCamp was a life member of the Iowa Medical Society.



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Medical Assistants



by BETTY EHLERT, CMA-A

MEDICAL EXAMINERS TO BE AAMA TEST CONSULTANTS

The American Association of Medical Assistants has named the National Board of Medical Examiners, Philadelphia, Pennsylvania, as its educational test consultant.

The NBME is a voluntary nonprofit testing organization which provides examination and testing services in three major categories:

1. The examination for physicians' National Board certification;
2. Examinations developed from National Board test material for state medical boards and foreign medical graduates; and
3. Examination services to other agencies, i.e., specialty board certification, in-training exams

and self-assessment of continuing education.

An expansion of this latter category occurred in 1976, when the NBME extended its services to include allied health groups whose educational programs and/or certification processes have medical profession participation. AAMA is the third allied health association to work with the NBME, the others being physicians' assistants and pediatric nurse practitioners.

The AAMA is dedicated to the professional advancement of medical assistants who handle both administrative and clinical duties in the physicians' offices and other medical facilities. As the first professional organization for medical assistants (founded 1956), AAMA pioneered in developing the only certification program in this field. More than 7,500 certificates have been earned since the first examination was given in 1963.

1978 CERTIFICATION PROGRAM

The National Board of Medical Examiners will begin work with AAMA in the preparation of the 1978 certification examinations to be offered in the spring and fall at more than 100 test centers nationwide.

The spring examinations (basic Certification Examination as well as the administrative and clinical specialty categories) will be given June 2, 1978.

The basic examination will be offered a second time—this time in the winter and at all test centers, instead of in the fall at the convention site.

The date of the winter exam (basic only) will be January 26, 1979. Application deadline dates are as follows:

FOR THE SPRING EXAMINATIONS—January 15, 1978.

FOR THE WINTER EXAMINATION—October 1, 1978.

This new schedule will make the examinations available to many more candidates than previously and will be particularly helpful to students.

Major changes have been made in the *eligibility requirements* for the examination. Medical assistants interested in taking the 1978 examination should write the American Association of Medical Assistants Certifying Board, One East Wacker Drive, Suite 1510, Chicago, Illinois 60601.

LIST YOUR WANTS

CLASSIFIED ADVERTISING RATE—\$1 per line, \$10 minimum per insertion. NO CHARGE TO MEMBERS OF IOWA MEDICAL SOCIETY. Copy deadline—10th of the month preceding publication.

MUSCATINE, IOWA—needs two family physicians, obstetrician-gynecologist, ophthalmologist and otolaryngologist. Muscatine has a population of 23,000 and serves an area of 40,000. Construction has started on a new 4.5 million dollar addition and there is a new one million dollar clinic under construction. The community is 30 miles from University of Iowa and 30 miles from the Quad-Cities. Ten new physicians have located here in the last three years. We are continuing to upgrade the quality of medical care given to the community. If you are interested please send curriculum vitae and list of 4 references to David G. Kundel, M.D., Chairman, Recruitment Committee, 1501 Cedar Street, Muscatine, Iowa 52761.

PSYCHIATRIC RESIDENCY—Vacancies for position for January 1, 1978 for those who have a regular Iowa license or can obtain one by reciprocity or via FLEX. Prepare for career in private practice, community clinics or hospital based psychiatry. Emphasis on close supervision of intensive individual and group psychotherapy, OPD, children's unit, adolescent unit. Neurology affiliation with University of Iowa. The stipends are: 1st year, \$22,360; 2nd year, \$23,478; 3rd year, \$24,674. Intensity and diversity of training program appreciated best by personal visit. Contact T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa, 51012. Equal Opportunity Employer. Call Collect 712/225-2594.

ORTHOPEDIC SURGEON, OPHTHALMOLOGIST, OBSTETRICIAN-GYNECOLOGIST, INTERNIST-CARDIOLOGIST, OTOLARYNGOLOGIST—Wanted to join established 18-man multi-specialty group in north central Iowa. Immediate full financial partnership and outstanding benefits. New clinic building and hospital. Progressive community with excellent schools and recreational facilities. Write No. 1528, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

GENERAL SURGEON WANTED—Opportunity in rich farming community, west central Iowa. Beautiful, progressive city with new 100-bed hospital only five minutes away. Friendly community, good production contract, well-established 8-man group. Short time to full partnership. Call Ed Murphy, Carroll Medical Center, 502 North Court, Carroll, Iowa 51401. 712/792-1500.

WANTED—OBSTETRICIAN-GYNECOLOGIST, OPHTHALMOLOGIST, INTERNIST-CARDIOLOGIST, OTOLARYNGOLOGIST to join established 19-man multi-specialty group in north central Iowa. Immediate full financial partnership and outstanding benefits. New clinic building and hospital. Progressive community with excellent schools and recreational facilities. Write No. 1529, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

INTERNIST NEEDED—Excellent opportunity for active practice of general internal medicine. Four-man group in north Iowa. Midway between Des Moines and Minneapolis. Close to lake. Family vacation opportunities galore. Excellent art museum and school system. Starting salary, \$45,000 plus bonus. Modern hospital, 35,000 community with 100,000 drawing area. Phone collect at 515/424-0244.

FAMILY PHYSICIAN NEEDED—Growing community of 4,000+ needs 1-2 physicians. Two family physicians in town and 1 nearby. Join existing practice or solo practice available. Excellent recreation and economy; 60 miles from metro cities; and 57-bed J.C.A.H. hospital in community. Trade area of 12,000+. U.S. graduate preferred. Contact L. Wattier, Administrator, Memorial Hospital, Inc., 104 W. 17th, Schuyler, Nebraska 68661. Phone 402/352-2441.

RADIOLOGIST—Immediate opening for board certified or eligible radiologist in 100-bed hospital in lakes area of N.W. Iowa. Hospital has recently completed a new radiology department and is now adding \$2 million addition including the addition of 50 acute care beds. Contract negotiable. For information, contact Mr. Charles Earhart, Administrator, Spencer Municipal Hospital, Spencer, Iowa 51301. Phone 712/262-3450 or call J. X. Tamisiea, M.D., Chief of Staff, 712/338-4788.

OCCUPATIONAL HEALTH OPPORTUNITY—Major midwest manufacturer has challenging opportunity in occupational medicine at Waterloo, Iowa. Salary commensurate with experience. Liberal fringe benefits including paid vacation, CME, life insurance, retirement and health coverage. Malpractice insurance paid. Send curriculum vitae to B. H. Shevick, M.D., John Deere Road, Moline, Illinois 61265.

STAFF PHYSICIAN FOR FAMILY PRACTICE RESIDENCY PROGRAM—Duties include teaching and supervising residents, plus direct patient care. Will join two-full-time-physician faculty in new model office. Approved program is affiliated with University of Iowa College of Medicine. Good salary and fringe benefit package, plus opportunity for postgraduate study. Contact: Charles A. Waterbury, M.D., Program Director, 441 East San Marnan Drive, Waterloo, Iowa 50702.

GOLDEN OPPORTUNITY—for a physician in a fast growing, very professional eastern Iowa town of 6,500, 20 miles from the Mississippi. Assume busy practice of deceased doctor. Office one block from county hospital. Call 319/652-4367 or 515/279-7373.

OBSTETRICIAN-GYNECOLOGIST, INTERNIST-CARDIOLOGIST, OTOLARYNGOLOGIST—to join established 19-man multi-specialty group in north central Iowa. Immediate full financial partnership and outstanding benefits. New clinic building and hospital. Progressive community with excellent schools and recreational facilities. Write No. 1530, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

F.P.'s NEEDED—Growing community of 4,000+ needs 1-2 M.D.'s. Two family practitioners in town and one nearby. Join existing practice or solo available. Excellent recreation and economy. 60 miles from metro cities. 57-bed J.C.A.H. hospital in community. Trade area of 12,000+. U.S. graduate preferred. Contact L. Wattier, Adm., Memorial Hospital Inc., 104 West 17th, Schuyler, Nebraska 68661. 402/352-2441.

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President's Page

The recent release of federal planning guidelines has provoked considerable discussion in Iowa by those who provide health care, and those who receive it. There is justifiable concern about arbitrarily applying the same "numbers" (hospital bed/population ratio, average occupancy rates, minimums for obstetric and pediatric units) to all states, regardless of size, geography, population density, physician distribution, and other factors.

IMS representatives have conferred with officials of the Iowa Hospital Association and the American Medical Association, and each of our organizations will submit recommendations to HEW regarding appropriate changes and modifications in the guidelines.

The IMS continues to monitor health planning activities in the state via participation in the Iowa Health Systems Agency and its various committees, task forces, and the State Health Coordinating Council. Contacts are also maintained with the State Health Planning and Development Agency. Four M.D.'s, and one D.O., serve on the IHSA Board of Directors; more than 20 physicians are serving on IHSA Subarea Advisory Councils; and two physicians are members of the State Health Coordinating Council.

I urge all physicians to become aware of the planning process, especially at the subarea level. All meetings of the IHSA Board and Subarea Councils are open to those interested.

Next March, the IMS, IHSA and the Iowa Hospital Association will sponsor a conference on health planning in Des Moines, at which time attention will be focused on methods of implementation of the health systems plan in Iowa.

In the meantime, we shall try to keep you apprised of health planning developments through the IMS UPDATE and other communications. Speak up!

I hope you have a Merry Christmas and try not to forget we all once believed in Santa Claus.



L W Swanson M.D.

L. W. Swanson, M.D., President

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JOURNAL OF THE

IOWA medical society

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DECEMBER 1977

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IOWA Medical Miscellany

CONVENES . . . The second session of the current biennium will convene January 9. Legislation introduced in 1977 will carry over for consideration by the lawmakers in the coming several months. The IMS Legislative Committee is scheduled to meet in early December to review Society priority measures—in terms of support and opposition.

LEGISLATIVE GOINGS-ON . . . The Society's legislative contact physicians (LCP's) will be briefed January 11 at a special IMS conference aimed at highlighting the forthcoming 1978 session of the Iowa General Assembly. Colorful Paul Newman, who is an active and successful political consultant, will be a featured speaker at the January 11 meeting. Officers of IMPAC and members of the IMS Legislative Committee will be urged to attend. All IMS members interested in the legislative process are welcome. The meeting is at Society headquarters.

SPECIALTY OFFICERS . . . A briefing for officers of Iowa's medical specialty groups will occur January 11 at Society headquarters and under IMS sponsorship. Political analyst Paul Newman will also speak to the specialty representatives. Offered the past several years, the program provides for input from the specialty groups as to the major issues confronting each.

CME DEVELOPMENTS . . . IMS representatives met November 9 with an ad hoc committee of the Iowa State Board of Medical Examiners and officials of the Iowa Society of Osteopathic Physicians and Surgeons to consider the continuing education requirements contained in the new Iowa law. No definitive action was taken, however support appeared to favor requiring Iowa medical license holders to obtain 20 Category I hours each year. Further development and refinement of the rules will continue into 1978.

BLUE CROSS/BLUE SHIELD . . . 1978 basic benefits will cost the same for IMS member physicians who participate in the Statewide Physicians Group Health Program. The community-rated Major Medical will increase by \$1.55 per month for single coverage and \$3.90 per month for family coverage. A mailing on the program was circulated in November.

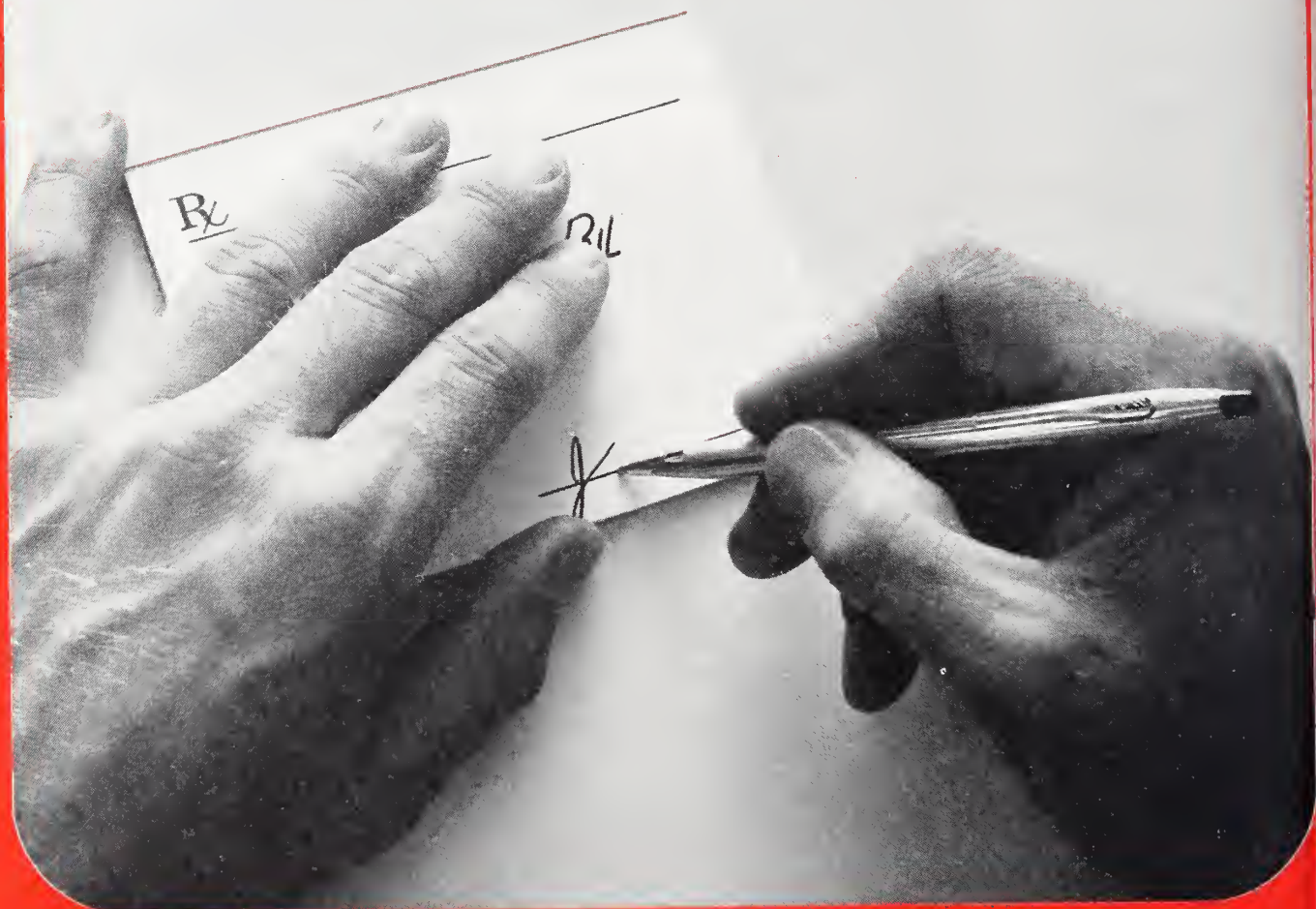
FILED WITH HEW . . . The IMS filed in November with the Department of Health, Education and Welfare its comments relative to federal health planning guidelines relating to hospital bed/population ratios, occupancy rates, etc. These arbitrary guidelines have stimulated much reaction and could have substantial impact on rural health care if implemented.

MD-RN COMMITTEE . . . The IMS MD-RN Liaison Committee met November 11 and recommended for approval by the Executive Council statements describing functions of the professional nurse in 5 areas: arterial punctures, removal of cantor tube, removal of vaginal packing, removal of sutures and ear irrigation.

TITLE XIX COUNCIL . . . Iowa's Medicaid Advisory Council, made up of providers and consumers, met at IMS Headquarters November 17 to consider financial and other aspects of the program. Concern exists over the possible need to execute agreements with individual providers; this function has been regarded as properly fulfilled through the signing of the claim form.

STUDY STRUCTURE . . . Preliminary consideration is being given to a study of the Society's organizational structure, particularly as it relates to the functions of the Board of Trustees, Judicial Council and IMS committees. Prospects are that an ad hoc committee will be formed in January to evaluate the subject.

There is no substitute



yours...

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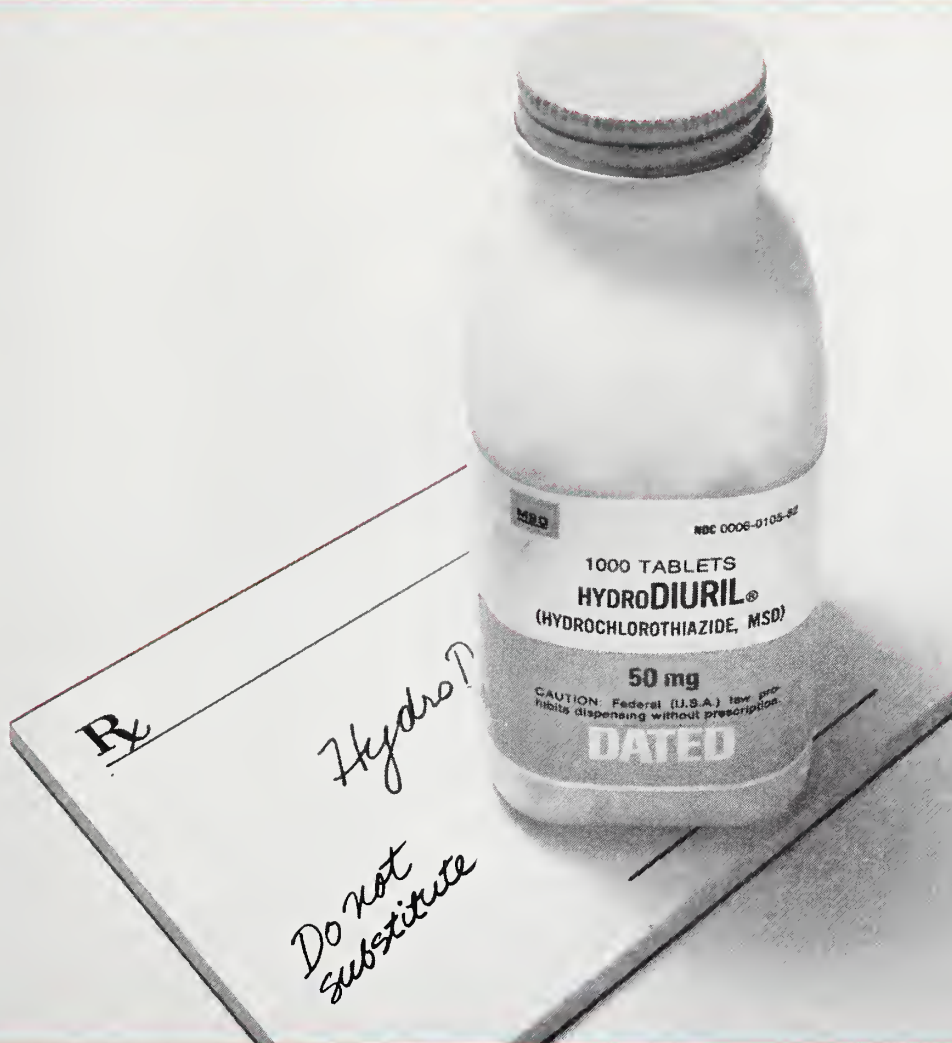
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.

Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting ex-

cessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice. Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

pairment becomes evident, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.

Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System—Dizziness; vertigo; paresthesias; headache; xanthopsia.

Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.

Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be

reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

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Pulmonary Perfusion and Ventilation Studies in Intrathoracic Malignancies

HAMED H. TEWFIK, M.D.,
HUSSEIN M. ABDEL-DAYEM, M.D.,
FERIAL A. TEWFIK, M.D., Ph.D., and
HOWARD B. LATOURETTE, M.D.
Iowa City

Observations from this study indicate peripheral lesions usually produce areas of perfusion defect localized only to the affected lobe or segment. These lesions receive their blood supply mainly from the bronchial arteries and infiltrate the lung parenchyma.

RADIOISOTOPE LUNG SCANNING in intrathoracic malignancies is useful in visualizing perfusion changes and contemplating treatment parameters. Ventilatory changes due to intrathoracic malignancies are equally important in the management of these patients. Radioactive xenon¹³³ given intravenously or by inhalation is used to study changes in pulmonary ventilation. These radioisotopic techniques have the advantages of being simple, accurate and give regional information.

METHOD

In this study, intravenous I¹³¹ macroaggregated albumin and intravenous xenon¹³³ dissolved in saline were used for study of perfusion

and ventilation changes in patients with intrathoracic malignancies. I¹³¹ macroaggregated albumin was given intravenously to the supine patient in doses of about 300 microcuries. Views were taken in the anterior, posterior and both lateral projections using the Nuclear Chicago gamma camera. In some cases, the rectilinear scanner was also used. To study pulmonary ventilation, xenon¹³³ dissolved in saline was given intravenously in doses of about 10 millicuries while the patient was sitting with his back facing the gamma camera. The patient was breathing through a closed tube arrangement attached to an exhaust system. Five seconds after the injection, the patient was asked to hold his breath for 15 seconds. During this time, the first picture was taken. This period represented the perfusion phase. The patient was then asked to breathe normally. The second picture was taken between 20 and 60 seconds after the injection. Serial

The Drs. Tewfik and Dr. Latourette are associated with the Department of Radiology at University of Iowa Hospitals and Clinics, Iowa City, Iowa. Dr. Abdel-Dayem is serving in the Department of Radiology at the School of Medicine, State University of New York, Buffalo, N. Y.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS
THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF DECEMBER 1977.

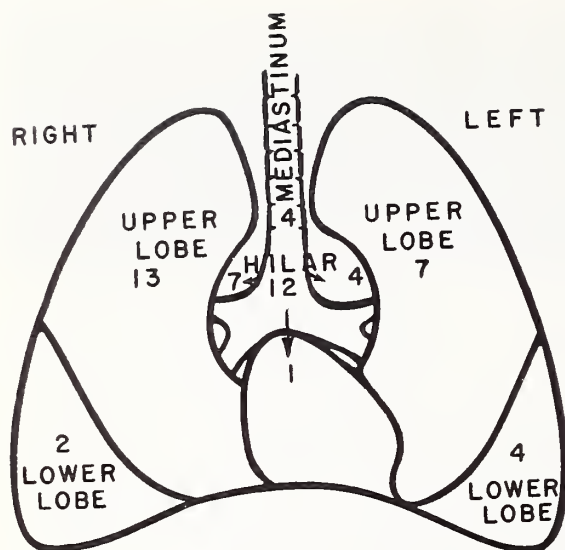


Figure 1. Lesion site in 42 cases of intrathoracic malignant lesions.

pictures were taken after that every minute up to 10 minutes. These pictures represented the washout of xenon from both lung fields. These scans were always interpreted in conjunction with chest PA and lateral films taken on the same day of the study.

MATERIAL

Forty-two patients (39 males and 3 females) with different intrathoracic malignancies were examined for pulmonary perfusion and ventilation by these techniques before starting radiation therapy. Their ages varied between 37 and 85 years.

Figure 1 shows the distribution of the lesions in the thoracic cavity. Thirty-eight patients had bronchial carcinomas (26 peripheral and 12 hilar lesions) and four had mediastinal lesions. The pathological varieties are listed in Table I.

RESULTS

Table II shows the changes in perfusion and ventilation in 26 cases of peripheral bronchial carcinoma. All cases but one showed perfusion defects in the affected lobe (Figure 2 a, b, c).

Table III shows the changes in perfusion and ventilation in 12 cases of hilar malignancies. All had marked diminution of perfusion to parts or all of the lung on the affected side.

Regarding the distribution of perfusion and ventilation in the four cases of mediastinal le-

sions the findings were as follows: In the lymphosarcoma case, the mediastinal lymph nodes were greatly enlarged and the left diaphragmatic leaflet was elevated. There was marked diminution of perfusion in the left side, and there also was retention of xenon in the left lung base. In the other three cases of esophageal carcinoma, sminoma, and Hodgkin's disease, the mediastinal lymph nodes were moderately enlarged, and they showed normal perfusion and ventilation studies.

TABLE I

Pathological Type	No. of Cases
A. Bronchial carcinomas	38
1. Biopsied	34
a. Well differentiated squamous cell carcinoma	19
b. Anaplastic squamous cell carcinoma	13
c. Oat cell carcinoma	1
d. Adenocarcinoma	1
2. Non-biopsied (positive sputum cytology)	4
B. Mediastinal lesions	4
1. Squamous cell carcinoma middle third of the esophagus	1
2. Lymphosarcoma (lymphocytic lymphoma)	1
3. Hodgkin's disease	1
4. Metastatic seminoma	1
Total number of cases	42

TABLE II

DISTRIBUTION OF PERFUSION AND VENTILATION IN 26 CASES WITH PERIPHERAL BRONCHIAL CARCINOMA

Findings	Number of Cases
I. Perfusion defect in affected lobe only	16
1. No retention of xenon washout from either lung field	10
2. Xenon retention* in the affected lobe only	2
3. Xenon retention outside the affected lobe only	2
4. Xenon retention both in the affected lobe and in other lobes	2
II. Perfusion defect in both the affected lobe and in other lobes	9
1. No xenon retention	3
2. Xenon retention in areas outside the affected lobe only	4
3. Xenon retention both in the affected lobe as well as in other lobes	2
III. No perfusion defect in the affected lobe	1
(The patient had a small rounded lesion in the lingula that failed to show perfusion or ventilation defect at the site of the lesion).	
Total number of cases	26

* By xenon retention, we mean delayed washout of the radioactive xenon from the lungs.

DISCUSSION AND CONCLUSIONS

Previous investigators studied the mechanisms by which bronchial carcinomas produce perfusion defects in the lung scan. Quinn and Head¹ postulated three possible causes for decreased pulmonary flow: a) the pulmonary artery may be compressed or infiltrated by the primary tumor or involved hilar nodes, b) as the tumor is supplied primarily by bronchial arteries it will not receive the radioactive particles, and thus show decreased activity, and c) regional hypoxia due to the presence of the tumor in the bronchial tree may result in reflex diminution of regional perfusion. Wagner and his associates² found that inflation of a balloon catheter within a segmental bronchus, with preservation of adequate air

TABLE III

DISTRIBUTION OF PERFUSION AND VENTILATION IN 12 CASES OF HILAR LESIONS

Findings	Number of Cases
I. Perfusion defect on the same side of the lesions only	9
1. Delayed washout of xenon in the affected side only	4
2. Delayed washout of xenon in the opposite side only	2
3. Delayed washout of xenon in both lungs	3
II. Perfusion defects on both sides	3
1. No xenon retention	2
2. Xenon retention in both lungs	1
Total number of cases	12

flow, caused ischemia of the canine lung. As a result, they have questioned whether a carcinoma arising in a bronchus may not impair flow through the accompanying pulmonary artery. Olsen and Ernest³ also suggested that peripheral lesions without hilar involvement may, in some way, cause capillary dilation or opening of arteriovenous anastomoses, thus allowing passage of the aggregates through the pulmonary capillary bed without allowing trapping.

Studying physiologic changes in carcinoma of the lung, Germon *et al*⁴ found most patients have preexisting lung disease detectable by physiological testing and lung scanning. The non-specificity of pulmonary function studies makes it impossible to relate abnormalities to the singular effect of either underlying chronic obstructive lung disease or to tumor. Radioactive xenon¹²³ has been used in the study of regional pulmonary perfusion and ventilation. Wagner⁵ and his associates were able to differentiate perfusion

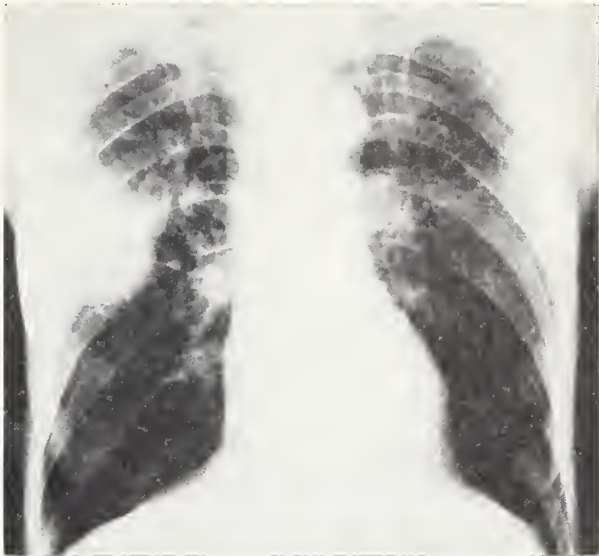


Figure 2a

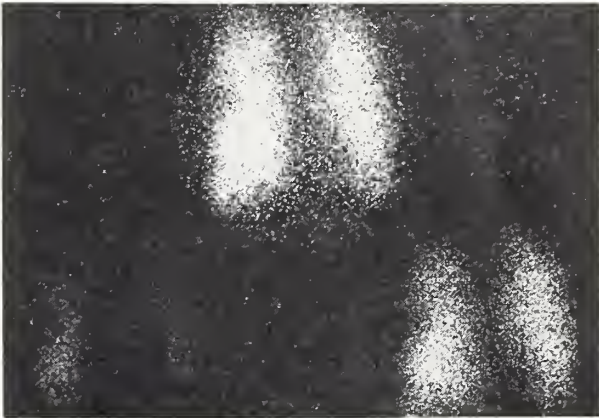


Figure 2b

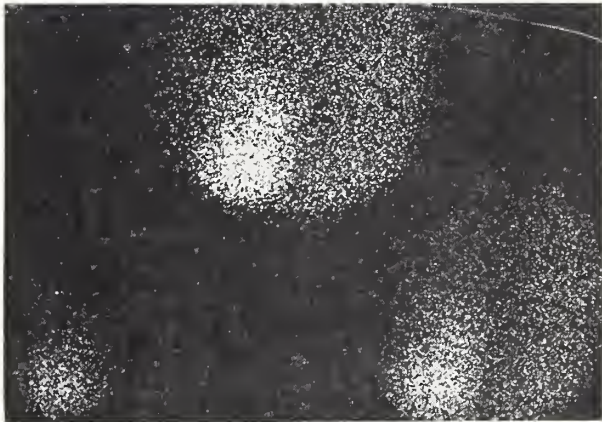


Figure 2c

Figure 2. Undifferentiated carcinoma of the right upper lobe: a) Chest x-ray showing a peripheral rounded opacity in the right middle lung zone. Fibrotic strands in both apices with bilateral emphysematous changes in both bases. b) ¹²³I MAA lung scanning, anterior view showing diminished perfusion to the area of the tumor on the right side. c) Xenon washout posterior view at 6-7 minutes showing no retention in the area of the tumor, but there is retention in the right base.

defects due to pulmonary embolism from obstructive lung disease using xenon¹³³. Mishkin⁶ studied the experimental models of a pulmonary embolus, bronchial obstruction and embolus combined with bronchial obstruction in three groups and found that pulmonary embolism is not accompanied by significant regional air trapping. Bronchial occlusion shows accompanying perfusion abnormality and marked xenon¹³³ trapping. Pulmonary artery occlusions with bronchial obstruction shows absence of xenon¹³³ activity and no entry of xenon¹³³ into the lung via the systemic circulation of the bronchial tree.

Our observations showed that, due to the presence of parenchymal spread of the neoplasm or associated obstructive fibrotic pulmonary disease, peripheral lesions usually produce areas of perfusion defect localized only to the affected lobe or segment. It is rare for a peripheral lesion not to show a perfusion defect. These lesions do not receive their blood supply from the pulmonary arteries, but mainly from the bronchial arteries. They also infiltrate the lung parenchyma, therefore, they usually do not manifest xenon retention in the affected segment. The presence of other areas of perfusion or ventilation defect was an indication of the presence of one of the following conditions: fibrotic or emphysematous lung disease, metastatic spread to the mediastinal lymph nodes, tumor spread to adjacent pulmonary segments or pressure on nearby bronchi.

Hilar lesions have a central position very close to the major pulmonary vessels and main bronchi. Pressure on the vessels or obstruction

of the bronchi, whether partial or complete will affect the perfusion to parts or all of the lung on the same side. The degree of this perfusion defect cannot be predicted from its radiological appearance. This may be associated with a ventilatory defect depending on the patency of each of the vascular and bronchial pathways and on the amount of functioning pulmonary tissue left behind. The presence of pleural effusion in the affected side in one patient caused retention of xenon in the remaining aerated pulmonary tissue above the level of the pleural effusion. Associated chronic pulmonary disease in this group of patients will further affect the state of perfusion or ventilation on the side of the lesion as well as the contralateral side.

Mediastinal lymphadenopathy do not produce perfusion or ventilation changes until they become greatly enlarged. Medium sized mediastinal lymph nodes as well as esophageal carcinoma do not primarily affect perfusion or ventilation.

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January 4	Ophthalmology Clinical Conference	March 3	Otolaryngology Clinical Conference
January 23-26	Cardiology Today	March 4	Iowa Radiological Society
January 26	Radiation Therapy Seminar	March 13-16	Cardiology Today
February 1	Ophthalmology Clinical Conference	March 15	Diet Therapy U.S.A.
February 3	Otolaryngology Clinical Conference	March 23	Radiation Therapy Seminar
February 14-17	Refresher Course for the Family Physician	March 29-30	Conference on Perinatal Medicine, Des Moines

Treatment of Alcoholism and Chemical Dependency

By Therapeutic Community Approach

RAYMOND MOORE, Ph.D., and
STANLEY HAUGLAND, M.D.
Des Moines

How to deal with crisis! This is the goal of this Iowa alcohol treatment program. Alternatives to chemicals are sought in a close "community" environment.

THE CONCEPTS of Alcoholics Anonymous (AA) have been combined with community mental health concepts at the Iowa Methodist Medical Center to form a therapeutic community treatment program. This is an intensive inpatient experience in a general hospital setting which lasts approximately four weeks. Over 1,500 patients have been treated in this program.

The key element in this program has been that of maximizing the *visibility* of each patient while he is in a highly structured but highly benevolent community. Each patient receives a regular flow of information about himself back from the immediate and surrounding community. This extensive feedback facilitates patient learning about unconscious motives, interpersonal style, defenses, and *especially* the system of excuses and rationalizations. It is through the latter that the patient has given himself permission to continue regular intoxication and (1) disrupt his family, (2) jeopardize his health, (3) sacrifice job performance, and (4) disregard himself and those who depend upon him.

There are 60 members in this treatment community (40 patients/20 staff). This means 60 pairs of eyes and ears probe all corners of the unit. When the patients individually are living in harmony with the community value system (not just verbalizing) they are appreciated and valued by the whole community. They are made aware

of this through appreciative words and gestures. On the other hand, when a patient is unfair, phony, or violates the value system in any one of many possible ways, the offender is immediately confronted and a penetrating analysis of his motives is undertaken by the entire community.

CRISIS INTERVENTION

It is not possible to be intoxicated regularly over a significant period of time and maintain health, care-of-self and family, job performance, safety, etc. Up to a point the patient is able to juggle priorities by using manipulation, denial, excuses and neurotic mechanisms. Eventually, however, health breaks down, family and employer rejection appears and the person faces a crisis (a problem which is novel and cannot be handled quickly with existing coping and defense mechanisms).

The patient enters treatment faced with termination of employment, divorce, imprisonment, and/or severe health problems. He is filled with rage, resentment, and the belief he can con his way through the program. But if the pressure is maintained and the crisis is kept alive, he must grow and develop new coping mechanisms in order to resolve the crisis. Patients are detoxified, isolated from the outside world at first, and placed in a treatment community, but they are not yet members of the community. They wear green hospital pajamas and robes. They stand out visually from other patients who are wearing street clothes. The new patients differ also in at-

The authors are associated with the Powell III Alcohol Treatment Unit at the Iowa Methodist Medical Center in Des Moines, Iowa. Dr. Haugland is medical director of the Unit.

titude from the community members, which is why they are not yet welcomed into the community.

All patients attend daily lectures, movies, small group and individual counseling. However, the core of the program is the daily community setting (meeting) which is attended by all the patients and staff. New patients are expected to recite from memory the first three AA steps and concepts listed below:

Step 1: "We admitted we were powerless over alcohol and other drugs, that our lives had become unmanageable."

The concept of Step 1 is: "That we are powerless because it is an illness. We didn't ask for it, but we are victims. Our lives always have been, are now, and always will be unmanageable since we can't accurately predict the outcome of every situation. We can only be responsible for the effort we put into whatever we do and take credit for the effort. If we put forth our best effort we can handle the outcome whatever it is."

Step 2: "Came to believe that a power greater than ourselves could restore us to sanity."

The concept of Step 2 is: "That the power is the AA program. Sanity is reality. Reality is seeing things as they really are and acting appropriately."

Step 3: "Made a decision to turn our will and our life over to the care of God as we understood him."

The concept of Step 3 is: "Follow the AA program. Not one person has failed who has sincerely followed the AA program. It works."

It is difficult for the new patient to recite these first three AA steps and concepts at a large meeting, but the community knows that after the patient leaves treatment, pressures will build, everything will go wrong at times, and the patient must have the program at a reflex level. Patients are tutored for this recitation by more experienced patients, and the tutors comment on the new patient's attitudes while trying to learn the first three AA steps.

The community relates to each patient in a way that allows negative behavior to create its own crisis which patients discover cannot be resolved by more of the same. For example, if a patient uses passivity as his major coping mechanism, others will not do his treatment work for him in this program. He will not progress in the program until he makes an effort on his own be-

half. As he sits back passively and watches other patients move on through treatment, as family and employer show concern that he is making no progress, it soon becomes conspicuous to him that his passivity is not controlling people as usual, but his passivity is getting him more deeply into trouble. Manipulation, sympathy seeking, hypochondriasis to avoid responsibility, and other negative behavior become a heavy burden to the patient in this community rather than a free ticket through treatment. The heroes of this community are the patients who put forth their best effort with good intentions. There is indifference to status outside the community, whether they be university president, physician, or Pulitzer Prize winner.

Rote memorization of these first AA steps is only the beginning of the patient's treatment. The patient must now begin to *apply* these to his/her life. We ask the patient to apply these to both what he has been and what he is currently.

TAKE A PERSONAL LOOK

The patient has not yet learned the lessons of his own past experience, therefore he has had to repeat the same mistakes again and again. If he does not learn these lessons in treatment he will continue to repeat these mistakes in the future. He has not yet learned because he has not fully faced the destructive consequences of his chemical dependency. Excuses and defenses have kept him from facing these realities. They must be destroyed by the treatment program. The patient is forced to look at his own history. Each patient is assigned to make a list of the ways in which he/she has interfered in the lives of others, a second list of his/her insanities while drinking, and a third list of the unmanageabilities of his or her life. When completed the patient must read these lists at the daily community meeting. The lists must be *specific*. The community will not accept vague, general statements.

If the patient says, "I've been unkind to my wife," the community will respond, "That's too vague. Be specific. Exactly what words did you say to your wife. Exactly what actions did you take toward your wife." In addition, the emphasis is on the specifics of the patient's negative behavior. If the patient lists the positive things he has done for his wife, the community may respond, "Your virtues did not get you into treatment. The only virtue we want to see right now

is your honest effort to face your negative behavior." For the sake of the patient's recovery, the community will expect a comprehensive list of specific items which truly represent a patient's negative behavior. If a patient has three children and does not mention any specific ways in which he or she has interfered in the lives of the children, the patient will be asked to take a penetrating look at this. One day each week the patient's family and/or other concerned persons spend the entire day in the program with the patient. On these days, the patient receives an enormous amount of feedback about the history of his or her negative behavior.

The patient is asked to study the unmanageable aspects of his or her life. He has been involved in damaging situations in the past and will have to face more of these unmanageable predicaments in the future. The patient's current feelings about the unmanageable aspects of his or her life are of considerable interest. For example, if a patient's brother stole the family business away from the patient 20 years ago, this was indeed an unfair blow. But the patient should have grieved and detached himself from the lost business long ago. If the patient is still deeply upset and resentful, 20 years later, it probably should indicate at least two things to him. First, this unhappy fate may serve as an excuse for drinking and drug use. Second, such a long term resentment indicates omnipotence and an infantile belief the patient can somehow turn reality around even after the situation resolved itself many years ago. The frustration tolerance is increased in our patients as a result of their taking a look at and accepting the unmanageabilities of their lives.

FEEDBACK ON CURRENT BEHAVIOR

In addition to facing past negative behavior and past unmanageabilities, we strive to maintain a psychological atmosphere which is immediately responsive to the here-and-now. Staff and patients alike are actively giving each other many "positive strokes," so much so that an outside observer might interpret this as excessive flattery over small achievements. In the transition from dependency on chemicals to dependency on oneself, there is a necessary intermediate step of dependency on positive feedback from others. The eventual goal is for the patient to get high on liking himself or herself, but the detached and shy patient who has been getting high on

chemicals cannot make this enormous transition in one giant step. The patients become very dependent upon being liked by other community members, and this dependency is not chemically destructive to their health or their functioning. With support from other community members, patients will eventually be able to get high on the fact that he or she is a person who puts forth his or her best effort with good intentions. Many patients will never reach this ideal completely, and will remain dependent upon peers in AA and other chemically free groups, but this interpersonal dependency is far superior to the alternative of chemical dependency.

Getting patients to give each other positive strokes is easy. But of equal importance is the difficult problem of getting Patient A to confront Patient B when Patient B is not putting forth his best effort or when Patient B has bad intentions and is not following the program. For example, imagine Patient B spontaneously goes up to a staff member who has just given a lecture, and Patient B tells the staff member, "That's the best lecture I've ever heard. You really opened my eyes to everything." Now let's imagine that Patient B goes further down the hall, out of the range of the staff member's hearing, and comments to a group of patients that the lecture was stupid. If Patient A happens to overhear the flattery to the staff member and the contradictory comments to the patients, Patient A should confront Patient B on his dishonesty. We are constantly facilitating confrontation between patients by explaining that it is difficult to confront, and that Patient A will be risking his popularity with Patient B. But if Patient A places his popularity above Patient B's treatment, then Patient A probably places his popularity above his own treatment, and Patient A had better take a look at his priorities. If any patient is allowed to leave treatment with his or her excuses and dishonesty intact, that patient must understand he will slowly commit suicide by using these excuses for further chemical dependency. If Patient A really cares about Patient B, Patient A must do everything possible to destroy Patient B's excuses and dishonesty.

OTHER FEEDBACK

In addition to feedback at the community level, patients also receive feedback in small groups and on an individual basis with their counselors. Patients dig more deeply into their

problems in small groups because there is more time available. But the theme of the work in small groups is harmony with each patient's work in the community. Weekly one-to-one sessions with the counselor are designed to explain to each patient his or her individual treatment plan and review his or her progress in terms of specific goals which have either been met or need further work. Flow sheets are useful in this regard, where goals are itemized and re-evaluated regularly. It is not the intention of the one-to-one sessions to treat the patient over on the sidelines, away from the community. We are committed to a group therapy model because the mutuality brings out in patients a harmony with the concept of the "higher power" of AA. When people get close to each other, they begin bringing out good things in each other. When patients first come into the program they are convinced they cannot stand to stay even an hour, let alone a month, but somehow the other patients manifest a desire to stay. This same positive mutuality between patients fosters courage to face one's dishonesty, destructiveness, carelessness, etc. Together, patients can find more courage, honesty and caring than they were previously able to find as individuals. However, we are not so naive that we believe all mutuality is positive. We also see patients who are bringing out the *worst* in each other. We welcome this, too, as more grist

for the "therapy mill." For example, if two or three patients gang up and support each other's rebellion against the treatment program, they are asked to take a look at the destructive influence they are having on each other. They are asked to look at the fact that if they prevent another patient from getting the program, they are hastening that patient's death, facilitating a destructive effect of that patient on his or her family, etc., etc. We ask patients to take responsibility for the bad influence they may have on another patient's treatment, and if they cannot curb this bad influence then to voluntarily stay away from that other patient.

SUMMARY

In summary, before coming into treatment, chemically dependent persons maintain their self destructive use of chemicals by excuses and defenses. Nevertheless, eventually, chemical use leads to a crisis which forces the patient into treatment. This crisis may be damage to health, marriage, threat of prison term, loss of job, etc. In treatment the patient is made visible and given an enormous amount of feedback to destroy the excuses and defenses through which he previously gave himself permission to continue chemical use. At the same time, the patient is offered alternatives to chemicals, such as an improved self concept, increased frustration tolerance and the positive mutuality of the community.

MEDICAL MISCELLANY

DRUG ABUSE/ALCOHOLISM . . . The IMS Committee on Drug Abuse/Alcoholism met November 9 with several agency representatives including John Tapscott, National Council on Alcoholism; Ronald Saf, executive secretary, State Board of Medical Examiners; Aaron Martinez, acting director, Iowa Drug Abuse Authority; and Gene Messenger, assistant director, Iowa Division on Alcoholism.

TRAVEL POSSIBILITIES . . . The IMS Board of Trustees has approved a working agreement with INTRAV, a travel organization, to provide travel opportunities for interested member physicians. Tentative plans call for the first trip to be an 11-day Rhine River Adventure in July.

ADOLESCENT PREGNANCY COUNCIL . . . Second meeting of this newly formed body occurred November 14 with representatives of the Society participating. Attempts are being made to determine the proper role of this multi-disciplined council.

SERVES . . . Erling Larson, Jr., M.D., Davenport, Iowa's senior delegate to the American Medical Association, serves this month on a reference committee at the interim meeting of the AMA House of Delegates in Chicago.

DON TAYLOR . . . D. L. Taylor has concluded his service with the Society as executive advisor and has accepted permanent disability on the recommendation of his physicians. Mr. Taylor served as the Society's chief administrative officer for many of his nearly 30 years of association with the IMS.

IOWA MEDICAL SOCIETY INSURANCE SERVICES AVAILABLE TO MEMBER PHYSICIANS

On the following two pages is a summary of the insurance coverages which are available from the Iowa Medical Society. All member physicians are invited and encouraged to review this outline to see if and where any of these coverages may fill a void in or supplement an existing individual insurance program. This suggestion is directed particularly to those physicians who are new to membership in the Society.

The Committee on Group Insurance of the Iowa Medical Society is responsible for the periodic evaluation of these programs to determine their value and receptivity. It is the further duty of the Committee to consider and recommend appropriate new coverages.

On the final page is a brief listing of those insurance coverages which are available to IMS member physicians who are active in the American Medical Association.

Any questions or comments regarding these programs may be directed to the administrator as shown or to the Headquarters of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265 (Telephone—515/223-1401)

INSURANCE PLANS FOR

TYPE	COVERAGE	SPECIAL FEATURES
1. PROFESSIONAL LIABILITY INSURANCE PACKAGE	Provides Basic Professional of \$100,000/\$300,000 or \$250,000/\$500,000 (depending on classification); Premises Liability; Catastrophic Liability From \$1 to \$5 Million.	Occurrence Form, Guaranteed 3-Year Market, Possible Expense and Loss Dividends, Active IMS Role in Loss Prevention & Control, Right to Insurability Hearing.
2. INCOME PROTECTION (ACCIDENT AND SICKNESS DISABILITY)	Optional Amounts Up to \$300 Weekly (\$1,300 Monthly) and Benefit Durations Up to Lifetime for Accident and to Age 65 for Sickness. Program Automatically Includes \$1,000 Accidental Death & Dismemberment, Waiver of Premium, a Rehabilitation Program and Loss of Use of Hand or Hands Benefit. Future Increase Option Available.	Benefits Begin First Day of Disability for Accident and Earlier of Eight Day Disabled or First Day Hospital Confined for Sickness. Optional Plans Available With Benefits Beginning the 29th Day, 57th Day, 92nd Day or 183rd Day. Claims Paid Directly From Administrator's Office. Special Renewal Features and Conversion Option Automatically Included.
3. OFFICE OVERHEAD DISABILITY COVERAGE	Available From \$200 Monthly to \$2,000 Monthly as Reimbursement for Office Expenses (Rent, Employee Salaries, Utilities, etc.) Incurred During Insured's Disability.	Benefits Begin After Waiting Period of Either 14 Days or 30 Days With Benefits Payable Up to 24 Months. Premium Tax Deductible. Special Renewal Features and Conversion Option Automatically Included.
4. TERM LIFE INSURANCE	Available in Amounts From \$10,000 to \$50,000. Guaranteed Renewable and Convertible to Age 70. Special Plans Available for Members of IMS Auxiliary in Amounts From \$5,000 to \$25,000.	Individual Policies. Renewal Rate Guaranteed. Waiver of Premium. Double Indemnity. Full Conversion Privilege Any Time. Dividends Reduce Premium.
5. EXCESS MAJOR MEDICAL	Pays 100% of Eligible Expenses After \$10,000, \$15,000, \$20,000, \$25,000 or \$50,000 Deductible Is Satisfied. Once Deductible Is Satisfied Plan Pays Up to \$300,000 per Person.	10-Year Benefit Period. 36 Months in Which to Satisfy Deductible. Guaranteed Issue. Renewable for Lifetime.
6. HIGH LIMITS ACCIDENTAL DEATH AND DISMEMBERMENT	Accidental Death, Dismemberment, Loss of Sight, Permanent and Total Disability Feature. Available From \$25,000 to \$150,000—Wife & Family Coverage Also Available.	24-Hour, World Wide Coverage. Aviation Coverage as Passenger. 365 Day Coverage. Renewable to Age 70. No Medical Underwriting.
7. HOSPITAL/MEDICAL	Two-option Coverage Available to Physicians, Their Families and Employees. Excellent Benefits to Cover Both Hospital and Medical Services.	365-Day Comprehensive Hospital. 365-Day Blue Shield UCR. Nervous/Mental, Drug Addiction, TB and Alcoholism. Major Medical Optional.
8. WORKERS' COMPENSATION	Provides Workers' Compensation Coverage as Required by State Law. Approved Rates Are in Effect. Program Meets Employer's Obligations for Occupational Injuries to Employees.	Is a Savings Plan in That Dividends Are Paid Based on Experience. 35% Return of Premium Has Occurred With Higher Percentage Possible. Safety Counsel Is Provided.

IA MEDICAL SOCIETY MEMBERS

ADMINISTRATORS

Aetna Life & Casualty
611 Fifth Avenue
Des Moines, Iowa 50309

The Prouty Company
2130 Grand Avenue
Des Moines, Iowa 50312

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Des Moines, Iowa 50312

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The Prouty Company
2130 Grand Avenue
Des Moines, Iowa 50312

Blue Cross/Blue Shield
Ruan Center
Des Moines, Iowa 50309

Casualty Reciprocal Exchange
Dodson Insurance Group
P.O. Box 559
Kansas City, Missouri 64141

INSURANCE COMPANY

Aetna Life & Casualty
Hartford, Connecticut

Commercial Insurance
Company
Newark, New Jersey

Commercial Insurance
Company
Newark, New Jersey

Bankers Life Company
Des Moines, Iowa

Insurance Company of North
America
Philadelphia, Pennsylvania

Insurance Company of North
America
Philadelphia, Pennsylvania

Blue Cross/Blue Shield
Ruan Center
Des Moines, Iowa

Casualty Reciprocal Exchange
Dodson Insurance Group
P.O. Box 559
Kansas City, Missouri 64141

ELIGIBILITY AND HOW TO APPLY

All Members May Apply Through Local Aetna Agents, The Prouty Company or Des Moines/Omaha Offices of Aetna. Information Available From Des Moines Aetna—1-800-362-1809 or 515-244-5145.

New Members Eligible for Base Amount of Coverage Regardless of Medical History, if Application Is Made in 90 Days of Membership. All Insurable Members Eligible Anytime Prior to Age 56. Coverage Continues to Age 70 for Active Members. Special Plan Available After Age 70. Apply to The Prouty Company—1-515-243-5255 or Toll Free—1-800-362-2860.

Applicant Must Be in Active Practice, Under Age 60, and Member of IMS. Apply to The Prouty Company—1-515-243-5255 or Toll Free—1-800-362-2860.

Any Active Member Under the Age of 65 May Apply. Apply to The Prouty Company—1-515-243-5255 or Toll Free—1-800-362-2860.

All Members, Their Families and Employees. Apply to The Prouty Company—1-515-243-5255 or Toll Free—1-800-362-2860.

Any Active Member Under the Age of 65, Spouse, and/or Family. Apply to The Prouty Company—1-515-243-5255 or Toll Free—1-800-362-2860.

All Members, Their Families and Employees. Apply to Blue Cross/Blue Shield.

Approved by the Iowa Medical Society for All Members. Apply to Casualty Reciprocal Exchange.

INSURANCE PLANS AVAILABLE FROM THE AMERICAN MEDICAL ASSOCIATION

TERM LIFE INSURANCE

Amounts of \$25,000, \$50,000 or \$100,000 available with double indemnity for accidental death, special "Loss of Use" and dismemberment benefits. Benefits reduce at age 65. New AMA members (under age 36) are guaranteed issue of \$25,000 without underwriting, provided they are actively engaged full-time in the normal duties of their profession and application is received within 90 days after membership is established.

DISABILITY INSURANCE

Monthly benefits up to \$3,000 after a 6-month or 12-month waiting period are available. The Plan contains a liberal definition of disability and a special return-to-work benefit. Once insured, renewal is guaranteed to age termination specified in the master contract, as long as the insured remains an AMA member actively engaged in his profession—even in the unlikely event the AMA cancels the master contract and does not replace it with another. New AMA members (under age 40) are guaranteed a \$500 monthly benefit without underwriting, provided they are actively engaged full-time in normal professional duties and application is received within 90 days after membership is established.

EXCESS MAJOR MEDICAL INSURANCE

Provides a choice of three deductibles—\$10,000, \$15,000 or \$25,000, with a \$1,000,000 maximum benefit for the member and each covered dependent. The benefit period begins after the deductible has been met and may continue for a maximum of five years.

HOSPITAL INDEMNITY

Provides a daily benefit of \$50, \$75 or \$100 during hospitalization of the member and his covered dependents. Benefits are payable from the first day of hospitalization up to 500 days.

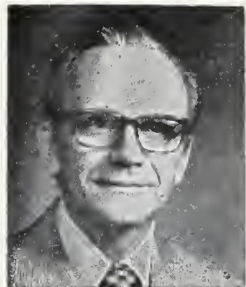
ACCIDENTAL DEATH INSURANCE

Provides a benefit of \$100,000, \$200,000 or \$300,000 for the member, with optional coverage available for the member's family.

OFFICE OVERHEAD EXPENSE INSURANCE

Monthly benefits up to \$5,000 are available in increments of \$500, with a 30-day waiting period. Benefits are payable for a maximum of 36 months. New AMA members (under age 40) are guaranteed a \$500 monthly benefit without underwriting, provided they are actively engaged full-time in normal professional duties and application is received within 90 days after membership is established.

For further information and application forms for insurance coverages on this page, please write William M. Mercer, Incorporated, 222 South Riverside, Chicago 60606, or call toll-free 800/621-0366. In Illinois call collect 312/648-6440.



Editorials

M. E. ALBERTS, M.D., Scientific Editor

CHRISTMAS

Thanksgiving Day officially opens the traditional year-end holiday season. Santa Claus parades sponsored by large department stores in our great cities herald the Christmas holidays. Our countryside takes on a fairyland atmosphere. Each merchant tries to out-do his competitors with lavish decorations either of a futuristic theme or of an old-fashioned flavor. A festive brotherly spirit pervades all modes of life—business houses are less somber, workers develop a more cheerful attitude, families often become closer, and children revel in all the glitter and tinsel in anticipation of forthcoming gifts.

Christmas is a season which has sharp contrasts. There is the festive side, the bells, the singing, the bright lights and colored papers; and also there is a sadness. Many people are alone, and their loneliness can be intensified by reflection upon the happiness of the past. Picture an elderly person,

no immediate family, a small room in a nursing home, forgotten by friends of the past, yet holding vivid memories of home and family in years gone by. How strong these poor souls must be to face the Christmas season. We must be alert to neuroses and conflicts which may linger in the ominous shadows of these persons' lives. In families where young ones may be severely afflicted, thoughts of the past and the uncertain future may overshadow the joys of the season. As physicians, we must help patients and "normal" persons through the shadows of Christmas neuroses. We must help our patients accept the ups and downs of life, to enjoy the precious blessings that are bestowed upon us through living, for it was by the birth of the Infant Jesus that we were given a new life. For those of us who rejoice in the Christian tradition we ought to give thanks in our prayers at this Holiday Season, as well as throughout the entire year.

Merry Christmas, and a Happy New Year from all of the JOURNAL staff.—M.E.A.

OUR AFFLUENT CHILDREN

A recent Gallup Youth Survey showed today's average teenager has a discretionary income of \$22 per week. The average amount received by teens in the upper age group (16-18 years old) is \$45, while for the 13-15 year-olds the amount is \$12. Yet, many respondents said their incomes did not meet their needs; 29 per cent claim they need more money—\$20 being the average additional amount needed. These "needs" are interesting, for the poll shows that boys spend 42 per cent and girls 38 per cent of their money for meals and snacks, 22 per cent and 16 per cent

for soft drinks, 17 per cent and 16 per cent for candy and gum, . . . interesting figures when one considers how much they consume at home.

Do teenagers need all the extra food and drink and candy? Much has been said about the poor nutritional and physical state of our youth. Theirs are lives of food, drink and automobiles—a life-style fostered by their parents and society as a whole. Yet, they accomplish great things with their social awareness through "hunger walks," bicycle jaunts and various marathons.

How do these figures compare with children of other countries? Recently, while in England, I learned from a news report that 11-13 year-olds have approximately 95 cents per week for per-

sonal spending, while the 14-16 year-old teens have \$1.10 per week (compared to \$12 per week for American 13-15 year-olds). I was impressed by a difference in the lifestyle of British as well as European youth—more walking and bicycle riding, fewer personal automobiles, fewer ice cream and hamburger establishments, and a greater number of museums, art galleries, and more knowledge of foreign languages.

I hope my remarks are not misconstrued. I mean not to conclude that our teenagers are spoiled worthless kids. I believe they reflect our

entire society, which is steeped in materialism and coupled with a corresponding loss of awareness of some of the finer aspects of life. True, our country is very young compared to others—our traditions are not backed by centuries of trial and error. We do not have that thread of the very old to bind the fabric of the present. Yet, perhaps it would behoove us to settle back and reflect upon where we are from and whence we are going. Our economy has become so inflated with material demands that the full value is lost behind false needs for those things which are so fleeting in nature.—M.E.A.

TETRACYCLINES MAL-PRESCRIBED

In 1975 the Committee on Drugs of the American Academy of Pediatrics made a strong stand against use of tetracyclines in children under the age of eight years. All drugs in the tetracycline family have little place in the treatment of children. Since 1970 the labels of such drugs have carried warnings of adverse effects upon children. Yet, tons of the drugs in liquid form were certified in a recent year by the Food and Drug Administration. Two recent reports by Ray, *et al*, decry the inconsistency of continuing to manufacture (in usual pediatric dosage forms) a drug not advised for children.

The studies of Ray and his group with Medicaid patients in Tennessee are distressing when one considers the abusive use of the tetracycline drugs in the care of children. Of 50,606 tetracycline prescriptions, 5.4% were for syrup and 0.2% were for drops. More than 55% of the prescriptions for syrup and 96% of the prescriptions for drops were for children less than 8 years of age. Thirty percent of these children were less than 2 years old, and 55% less than four years. An additional 22% of the syrup prescriptions were for children 8 through 14 years of age. Physicians in family practice prescribed the greatest quantity of tetracyclines. Surgeons and internists prescribed more of these drugs to young children than did pediatricians.

Adverse effects of tetracycline drugs upon young children are well documented. These include dental staining, enamel hypoplasia, inhi-

bition of bone growth, the "bulging fontanel syndrome," super infection by *Candida albicans*, gastroenteritis, phototoxicity and skin rashes. Furthermore, as pointed out by the AAP Committee on Drugs, it is difficult to identify common pediatric infections for which an oral tetracycline would be the drug of choice. Penicillin is preferable for streptococcal and pneumococcal infections; Ampicillin is first choice for *Hemophilus influenzae*; gram-negative urinary tract infections can be treated with sulfonamides, nitrofurantoin, ampicillin or cephalosporins. Mycoplasma pneumonia is responsive to erythromycin. One would wonder if tetracyclines represent "shot-gun" treatment for non-specific febrile illnesses. Rickettsial infections, for which tetracycline drugs may be indicated, are relatively rare.

It is obvious that in light of mal-prescriptions of tetracycline drugs to children further steps are necessary to stop this practice. It would appear that further action by the Food and Drug Administration will be required to restrict the distribution or labeling of tetracyclines in liquid form. Labels should make it more clear that these drugs are not for pediatric use, or such dosage forms be made unavailable. These drugs can not be justifiably used so indiscriminately (and often inappropriately) in light of evidence available to all physicians.—M.E.A.

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- Requiem for tetracyclines, Committee on Drugs, American Academy of Pediatrics. *Pediatrics* 55:142-143, 1975.
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The Question Box



by DONALD C. YOUNG, M.D.

NEW LEGISLATIVE SESSION

Dr. Young is the veteran chairman of the Iowa Medical Society Committee on Legislation. He practices radiology in Des Moines.

When does the 1978 legislative session begin?

The second session of the current legislative biennium will convene January 9, 1978.

What are the major health related issues likely to receive attention?

Over 100 bills with a medical significance were introduced during the 1977 session. About a dozen of these have a major impact on medicine and carry over. On the positive side, the IMS will support adequate appropriations for the Family Practice Residency Program, the Medicaid Program and the Board of Medical Examiners. We'll encourage the Senate to take up H.F. 179 which passed the House last year. It contains additional liability reforms. Several troublesome bills will likely be up in the coming months. The ones we'll oppose include: use of diagnostic drugs by optometrists; chiropractic expansion; hospital employment of radiologists and pathologists; ownership of records by patients; prescription writing by physician's assistants; statutory rights for patients. These deserve explanation beyond the space available here. For example, we certainly believe patients should and do have rights, but they need not be written into the Code. It appears there may be controversial legislation dealing with the sale of Laetrile.

What reminders do you have for IMS members in making their positions known to legislators on different bills?

It is important to make or renew a personal ac-

quaintance with your senator and representative. These last few weeks before the session begins are a good time for that. Secondly, please try to stay current on those legislative matters of interest to the IMS; this request is made particularly of those who serve as Legislative Contact Physicians. We want to transmit to legislators (through LCP's and others) information that's current and accurate. I urge you also to be aware of various non-medical bills which bear on the general population. Contact your legislators periodically with your opinions on these non-medical matters. Again, you'll find any contact during the legislative session will be more effective if you have taken time beforehand to meet with him or her to get acquainted. When you've presented medicine's position thank him/her for the time, also give him/her your phone number and address if there is a medical question on a bill that you can help with.

Are the 1978 IMS legislative priorities established?

Those mentioned above will be the key items undoubtedly. The IMS Legislative Committee will meet in December to review and further refine the priorities.

Will the IMS be informing member physicians about legislative developments?

Yes. We mail various publications to the membership. The LEGISLATIVE BULLETIN is issued on a need basis. I urge its readership. The IMS UPDATE and JOURNAL also carry references to legislative matters. The IMS MINI-MESSAGE is used for short and rapid reports on breaking issues. These usually request immediate contact work with legislators. 1978 will be another interesting and challenging legislative year. We need your informed interest and support!

Educationally Speaking



by R. M. CAPLAN, M.D.

LEARNING IS WHERE YOU FIND IT

Receptivity to learning might be considered the *open sesame* for continuing education. If one says, "I know what I know, and I'll use it as best I can," another may infer a mind that is not open to new thoughts and techniques. The open mind will react with curiosity: "Isn't that amazing?—What is the evidence for that?—If that's so, what would it mean to the way I practice medicine?"

Without an open mind, learning by trial and error won't happen. Trials will happen (probably unplanned), and certainly errors will happen; but the episodes will go unnoticed—nothing beneficial will result. It has been said that experience means you recognize your mistake when you make it the second time. And perhaps you've heard the old saw about the surgeon who performed an operation 80 times, but each time was as inept as the first one. To gain the benefit that is potentially available from experience, the mind must remain critical, analytical, always probing for what happened, what does it mean, what changes should be made for the future. Such a sense of inquiry plus the energy to keep track of experience, make a tally, gather data (or in the popular phrase of the day, *audit* your work) is what clinical investigation is all about. And there is no practitioner who lacks the opportunity to do that.

Learning happens in such diverse settings and formats! Some of the most important learning can occur from reading literature, and I here mean nonmedical literature. I mean "artistic" literature. The gifted writer can distill experience

from his life and caprices from his imagination and present them to an open-minded reader in a way that makes that reader learn something new in a memorable way, through the kindling of an emotional response as well as an intellectual one. You may read Kubler-Ross with profit

SPEAKERS BUREAU

The U. of I. Department of Continuing Medical Education has compiled a listing of faculty speakers (and their topics) who are willing to make presentations to county medical societies, hospital medical staffs, etc. Please contact Dr. Caplan for information in this area. His telephone number 1/319-353-5763.

(*On Death and Dying*) but the feeling of isolation cannot come more powerfully than in Tolstoy's *The Death of Ivan Illich*.

A new work has appeared that I urge upon you—a novel by the renowned New York neurosurgeon, Irving S. Cooper, entitled, *It's Hard to Leave While the Music's Playing*. The story of a patient's struggle with a fatal disease is excellently portrayed. Even more eloquent is his physician's struggle with the ethical issues surrounding the use of "extraordinary measures" to save life (or prolong dying). The solitary, personal judgment that physicians are called upon to make and the heaviness of that unique responsibility are portrayed in a courtroom drama that will keep you totally absorbed.

Go ahead and learn from your patient's response to a drug, or from attending a lecture, or from an article in the medical literature, or from the intensity of an experience in your own life, or vicariously from a literary character—all can be equally valuable. And all will happen to you if you can and will nurture the spirit of curiosity which is the basis for all of our adult learning.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

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State Department of Health

UPDATE ON H.F. 597

In the September issue a report was provided on the availability of state funds for local boards of health to expand public health nursing services, visiting nurse services, and homemaker home health aide services to additional elderly Iowans. House File 597 appropriated \$1,600,000 to the Iowa State Department of Health for this purpose.

The deadline for proposals was November 15, 1977. All local boards of health, except two

(Boone and Monroe Counties), have applied and are receiving funds under this legislation to make added services available to elderly Iowans.

All physicians are urged to refer patients who could benefit from this additional public health nursing or homemaker home health aide service to the appropriate local agency. Any questions regarding these funds which cannot be answered locally should be directed to: Ronald D. Eckoff, M.D., M.P.H., Chief, Division of Community Health, Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319, telephone 515-281-4910.

USE OF HYPERIMMUNE HEPATITIS B IMMUNE GLOBULIN

Hyperimmune Hepatitis B Immune Globulin (H-BIG) has been released by the FDA for post exposure prophylaxis following parenteral exposure, e.g., by accidental "needle stick," or direct mucous membrane contact (e.g., accidental splash), or oral ingestion (e.g., pipetting accident) involving HB_sAg positive materials such as blood, plasma or serum. The following information is available on its use and effectiveness.

H-BIG has an anti-HBs titer of 1:100,000 or greater, however, it has not been conclusively shown to be superior to Standard Immune Serum Globulin for the following reasons:

1) Both H-BIG and Standard ISG have been shown to be effective in preventing Hepatitis B, however, evidence suggests that H-BIG may prolong the incubation in some cases.

2) Standard Immune Globulin may be more effective in allowing passive-active immunization.

Another factor to consider is that the cost of immune prophylaxis with H-BIG is approximate-

ly \$300 in comparison to \$10-\$20 for standard ISG.

After taking these facts into consideration and consulting with the Phoenix Laboratories Division of CDC, the following are considered indications for use of H-BIG.

1) Exposure to a known inoculum of HBV via needle stick or mucosal surface. H-BIG should be given in a dose of .05-.07/cc/Kg within 7 days of exposure and repeated in 25-30 days. Standard ISG may be used in the same dosage if H-BIG is not available.

2) Infants born to mothers with acute Hepatitis B in the third trimester of pregnancy. H-BIG may be administered in a single dosage of .13 cc/Kg of body weight. Standard ISG may be used in a single dose of .5 cc/Kg.

Various authorities have expressed concern that H-BIG will be used indiscriminately and that a false sense of security will detract from efforts to prevent transmission of the disease by strict epidemiological and environmental control measures.

H-BIG is for use only in prophylaxis of Hepatitis B and not for Hepatitis A. It is strongly recommended that the HB_sAg test be performed on all cases of suspected viral hepatitis and that gam-

ma globulin be administered only when indicated. Consultation may be obtained by calling the Iowa State Health Department 1-800-362-2736.

A personal lecture on hepatitis is available for county medical society meetings and other ap-

propriate continuing education meetings. Arrangements may be made by contacting L. A. Wintermeyer, M.D., Director of Infectious Disease Control Section, State Department of Health, Des Moines, Iowa 50319. Phone: 1-800-362-2736.

KEOTA SALMONELLOSIS OUTBREAK

On July 5, 1977, 69 cases of acute gastroenteritis were reported to the Iowa State Department of Health from Keota, Iowa (population 1,112); 10 were confirmed as *Salmonella typhimurium*. Epidemiologic investigation of these cases as well as a community-wide survey for illness, water drinking history, and milk drinking history failed to conclusively implicate any common experience or source of infection. The survey identified 206 cases of gastroenteritis among 787 respondents (26.2%) for the period June 19 to July 19, 1977.

Since the distribution of cases was widespread in the community and since water samples yielded a *Salmonella enteritidis* isolate, municipal water would appear to be the vehicle of infection. This presumption is supported by an unsatisfactory coliform count of a water sample, irregularities of chlorination during the period prior to the outbreak, and salmonellosis in a patient with only a two-day exposure to the community. No confirmed source of contamination could be identified although a local poultry processing plant was considered since salmonellae are common to poultry and one resident reported collecting a feather from a water faucet!! Follow-up studies of water samples collected in late July and August were satisfactory.

Morbidity Report for October, 1977

Disease	Oct. 1977	1977 to Date	1976 to Date	Most October Cases Reported From These Counties
Amebiasis	4	99	31	Boone
Brucellosis	3	18	45	Dubuque
Chickenpox	352	7207	10127	Scattered
Conjunctivitis	129	1948	1677	Scattered
Gastrointestinal				
viral inf.	2049	19839	19045	Scattered
Giardiasis	4	49	25	Scattered
Hepatitis				
infectious	8	96	100	Scattered
serum	13	88	71	Scattered
unspecified	2	29	19	Appanoose, Dallas
Impetigo	137	671	762	Scattered
Infectious				
mononucleosis	133	944	909	Scattered
Influenza-like				
illness	3830	16553	44049	Scattered
Meningitis				
aseptic	1	14	13	Dallas
bacterial	2	5	—	Keokuk, Winnebago
Mumps	26	1213	1350	Scattered
Pediculosis	138	447	653	Scattered
Pinworms	2	33	30	Polk
Pneumonia	198	924	847	Scattered
Rabies in animals	10	111	117	Scattered

Disease	Oct. 1977	1977 to Date	1976 to Date	Most October Cases Reported From These Counties
Rheumatic fever	2	29	20	Davis, Lee
Ringworm				
body	52	284	223	Scattered
scalp	3	10	19	Scattered
Rubella (German				
measles)	4	171	88	Scattered
Rubeola (measles)	32	4306	44	Scattered
Scabies	200	919	640	Scattered
Streptococcal				
infections	850	10425	12660	Scattered
Tuberculosis				
total ill	6	74	98	Scattered
bact. pos.	6	62	86	Scattered
Venereal diseases				
Gonorrhea	463	4898	5609	Scattered
P. & S. Syphilis	5	37	19	Scattered
Syphilis (other)				
Salmonellosis	35	241	97	Scattered
Shigellosis	13	50	66	Scattered

Laboratory Virus Diagnosis Without Specified Clinical Syndrome

Adenovirus a/w Reye's Syndrome—1, Coxsackie B4—2, Cytomegalovirus—6, Eaton's Agent infection—11, ECHO type 4—1, ECHO infection unspecified—1, Herpes simplex—10, and Herpes zoster.

HEW'S NATIONAL GUIDELINES ARE HOT ISSUE

WHAT'S THE hottest health topic going? At least, what's hottest since September 23?

The answer is obvious if you follow health care news and are concerned at all over health care delivery in Iowa. On September 23, Health, Education and Welfare released proposed national guidelines for health planners. The subsequent eruption of local feeling has been considerable.

These HEW guidelines are broad, bold and seemingly disregard our country's unique variances. They propose a national goal which calls eventually for fewer than four hospital beds per 1,000 population—plus an average annual occupancy rate of at least 80% for all non-federal, short-term hospital beds. These mandates have produced a shock among congressmen, health administrators, health providers, and a lot of ordinary citizens that can be described as significant. Distress, bewilderment, uncertainty and frustration are other apt reactions to this HEW promulgation.

By the time this appears in print the normal 60-day period allowed for responding to proposed federal guidelines will have passed. While Iowa's congressional delegation has made effort to extend this time interval, the Iowa Medical Society filed its comments within the allotted time.

In its remarks, the IMS declared that the newly issued guidelines seem to run counter to their base point, the Health Planning and Resources Development Act of 1974 (P.L. 93-641). This controversial law established a massive and complex network of agencies to engage in planning and approving health facility growth within a specified area. At least the intent of the law, to a considerable degree, was to allow specific geographical entities to devise plans, assess proposals and generally oversee the destiny of health facility growth in a defined area (the Iowa Health Systems Agency covers 91 of Iowa's 99 counties).

In addition to hospital bed/population ratios and overall hospital occupancy, the arbitrary HEW guidelines mandate (a) at least 500 obstetrical deliveries in any unit in a small population area; (b) a pediatric unit (except in rural areas)

with a minimum of 20 beds along with annual occupancy levels applied to them; (c) neonatal intensive care beds not to exceed four per 1,000 live births per year in a defined neonatal service area; (d) open heart surgery activity only in facilities where a minimum of 200 procedures are done annually; and (e) other guidelines which relate to cardiac catheterization, radiation therapy, computed tomographic scanners and end-stage renal disease.

The IMS communication to HEW zeroed in on the hospital bed ratio as well as the occupancy rates. The letter characterized the federal guidelines as an unjustifiable threat to the accessibility of health care in Iowa. The IMS response criticized the disproportionate emphasis on short-term opportunity for cost containment and quality enhancement in the institutional sector to the detriment of accessibility of care in the rural area.

The Society charged HEW with discounting the demographic and population characteristics of Iowa in the issuance of its guidelines. As a rural state with a high portion of its citizens over 65, hospitalization for chronic conditions close to home has virtue. It often provides better therapy than would movement to a more distant, impersonal and larger facility. Factors such as these support the argument that national edicts to eliminate 4,042 Iowa hospital beds (that's the number reported to be in danger if the 4/1000 formula is imported) fail to consider important local criteria.

Moreover, as the IMS letter stated, the rapidly emerging and seemingly successful Iowa Family Practice Residency Program, which has placed much-needed family practice physicians in smaller communities, would suffer from an indiscriminate slash in hospitals either totally or partially.

The IMS epistle to Washington, D. C., will go into the huge HEW mailbox presumably with hundreds or even thousands of other communications. We can only hope the unique characteristics of local areas and the importance of local determination will receive the kind of prudent consideration they deserve.

IN THE PUBLIC INTEREST

About IOWA Physicians

Dr. Charles F. Johnson, professor of pediatrics and assistant director of the Child Development Clinic at U. of I. College of Medicine, has accepted the position of assistant dean for continuing medical education at a new medical school at East Tennessee State University in Johnson City, Tennessee. Dr. Johnson's duties will include developing and coordinating continuing education programs for physicians and allied health personnel and promoting continuing health education in the community. . . . **Dr. Clarence H. Denser, Jr.**, Des Moines, was recently appointed chairman of the Service and Rehabilitation Committee of the American Cancer Society. . . . **Dr. A. M. Nelson, D.O.**, Belmond, was cited recently by the MASON CITY GLOBE-GAZETTE for his 46 years as team physician for Belmond High School. A member of champion football teams in 1919 and 1920 in St. Paul, Minnesota, Dr. Nelson was named three years ago to the Iowa High School Athletic Association Hall of Fame. . . . At the September meeting of the Wright County Medical Society, **Drs. Donald P. Morgan and Victor Beat** of the Iowa Epidemiologic Studies Project at the U. of I., presented a program on "Herbicide and Pesticide Intoxication."

Dr. William R. Boulden, orthopedic surgeon, joined **Dr. Peter D. Wirtz** in Des Moines in November. Dr. Boulden received the M.D. degree at the U. of I. College of Medicine and completed his orthopedic residency at the University of Nebraska School of Medicine. He is the son of **Dr. Roger Boulden**, Lenox, current president of the Iowa Chapter, American Academy of Family Practice. . . . At the annual Clinical Congress of the American College of Surgeons, **Dr. Edward E. Mason**, professor, and **Dr. Kenneth J. Printen**, associate professor, in the Department of Surgery at the U. of I. College of Medicine, received an

award for their teaching film, "Gastric Bypass for Morbid Obesity," premiered at the meeting. . . .

Dr. John Martin, Clarinda, was guest speaker at the November meeting of the Johnson County Medical Society. His topic, "The Paduan School of Medicine: Versalius through Spigelius." . . . **Dr. Michael Hill**, otolaryngologist, joined the Wolfe Professional Clinic in Marshalltown in October. Dr. Hill received the M.D. degree at the U. of I. College of Medicine; interned at Santa Clara Valley Medical Center in San Jose, California; and completed his otolaryngology residency at Stanford University. . . . **Dr. Anthony H. Kelly** has been named president of the Marian Health Center medical staff; **Dr. A. Boldus**, president-elect; and **Dr. H. N. Hirsch**, secretary-treasurer. All are Sioux City physicians.

Dr. Thomas M. Foley, Marshalltown, has been named a fellow of the American College of Surgeons. . . . **Dr. Jim L. Wilson**, assistant professor in the Department of Family Practice at the U. of I. College of Medicine, participated in recent Webster City seminar for physicians and pharmacists. Topic of the special program "Treating Upper Respiratory Infections: The Family Physician and Pharmacist Team Up." . . . **Dr. Jeffrey Lavigne** has joined the Ottumwa Medical Clinic where he will specialize in general surgery and peripheral vascular surgery. Dr. Lavigne received his M.D. degree; served his surgery residency and a fellowship in vascular surgery at Downstate Medical Center in Brooklyn, New York. . . . **Dr. Harold W. Miller** began family practice in Davenport in October. Dr. Miller received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at Mercy and St. Luke's Hospitals in Davenport. . . . **Dr. Leo J. Miltner**, longtime Bettendorf orthopedic surgeon, was honored recently by members of the Davenport Visit-

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ing Nurses Association and the Mohassan Grotto for 38 years of service to the physically handicapped in the community. Dr. Miltner was presented a framed calligraphy tribute. . . . **Dr. Kie Yun Lee**, Webster City surgeon, has expanded his practice and is providing part-time coverage in family medicine in Stanhope.

Dr. G. L. Hoekstra, D.O., recently began family practice in Toledo. Dr. Hoekstra received the D.O. degree at the College of Osteopathic Medicine and Surgery in Des Moines and completed his family practice residency at Iowa Lutheran Hospital. . . . **Dr. C. W. Seibert**, Waterloo, was cited recently by the American Cancer Society for his 30 years of service to the Black Hawk County Chapter. Dr. Seibert was a founder of the Chapter, and is a past president of the Iowa Division and a lifetime honorary member of the state board. He is also the recipient of the ACS's bronze medal, the highest honor awarded to outstanding division volunteers, and the Harold W. Morgan Award for outstanding volunteer work. . . . **Dr. Ivan T. Schultz**, Humboldt, was honored recently by the ham radio operators of Humboldt County for his

training and assistance. A plaque bearing his call letters was presented to Dr. Schultz. His wife, **Dr. Nelle Schultz**, received her ham radio operator's license this summer in a class taught by Dr. Schultz. Drs. Ivan and Nelle Schultz came to Humboldt in 1932. Both are U. of I. College of Medicine graduates and interned together at Grand Rapids, Michigan. . . . **Dr. Deepak Midha**, Creston, has been named a member of the Union County Board of Health. . . . **Dr. Gilbert R. Clark**, Waterloo, was guest speaker at a seminar of the Black Hawk County Chapter of the American Association of Medical Assistants. Dr. Clark presented a film on autopsies followed by a question and answer session.

Dr. Bruce V. Andersen, Greene, was honored recently for 40 years of medical service to the Greene community. Dr. Andersen received the M.D. degree at the University of Nebraska Medical School and began his medical practice in Greene in 1937. . . . **Dr. Carl Vorhes**, a Sheldon physician for 25 years, has accepted a faculty appointment at the University of Minnesota Medical School in the Department of Family Practice and Community Medicine. Dr. Vorhes closed his Sheldon office in June following open heart surgery. . . . **Dr. Richard Hastings**, Ottumwa, was honored recently by the Wapello County Chapter of the American Cancer Society for his 20 years of service to the county and the Iowa division of the American Cancer Society. . . . **Dr. James W. Hanson**, Department of Pediatrics at the U. of I. College of Medicine, was guest speaker at the Iowa Science Teachers Fall Conference at Marshalltown Community College. Dr. Hanson's topic "Genetic Defects and Human Genetic Counseling." . . . **Dr. Preeti Bhatia**, pediatrician, has joined the staff of Medical Associates in Clinton. Dr. Bhatia received her medical education in New Delhi, India, completed internships and residencies in New Delhi and Brooklyn, New York. Dr. Bhatia is certified by American Board of Pediatrics; member and associate fellow of the American Academy of Pediatrics; and associate fellow of the American College of Allergists. Prior to locating in Clinton, Dr. Bhatia was on the staff of St. John's Episcopal Hospital in Brooklyn, New York.

Dr. J. Scott Pennepacker, Sioux City, was guest speaker at a seminar for resident pathologists in
(Please turn to page 496)

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N.W., WASHINGTON, D. C. 20005

ABOUT IOWA PHYSICIANS

(Continued from page 494)

Las Vegas, Nevada. His topic: "Lab Management and Finances." The seminar was sponsored by the College of American Pathologists. . . . **Dr. Paul From**, Des Moines, was named "Boss of the Year" by the Des Moines Chapter of the American Business Women's Association. Dr. From is director of the Cardio-Vascular Pulmonary Laboratory at Mercy Hospital in Des Moines. . . . **Dr. John F. Murphy**, Boone, attended a recent advanced cardiac life support training program in Okoboji sponsored by the Iowa Heart Association. **Dr. Robert H. Kuhl**, Creston, was guest speaker at a recent meeting of the Greater Community Hospital Auxiliary. Dr. Kuhl presented a slide travelogue entitled, "Holiday on Two Wheels," reviewing a summer bicycle tour he and Mrs. Kuhl took through The Netherlands.

Dr. John Kasik, professor of medicine and director of respiratory therapy, Oakdale Hospital, and **Dr. Miles H. Weinberger**, director of pediatric allergy and pulmonary division, University Hospitals, were program participants at the Fifth Annual Mid-West Conference on Chest Diseases in Omaha, Nebraska.

DEATHS

Dr. Gerhard Grundberg, 74, Maquoketa, died October 10 at Iowa Methodist Medical Center in Des Moines. Dr. Grundberg received his medical education in Latvia and interned at Iowa Lutheran Hospital in Des Moines. He was a member of the American Academy of Family Physicians.

Dr. Ludwig Gittler, 79, Fairfield, died October 11 at the Jefferson County Hospital. Dr. Gittler was born in Poland. He came to the United States in 1924 and practiced medicine in Chicago before locating in Fairfield in 1939.

Dr. Sidney L. Sands, 63, Des Moines, died October 14 at Iowa Lutheran Hospital. Dr. Sands received the M.D. degree at U. of I. College of Medicine and served his residency in psychiatry at Worcester, Massachusetts. He located in Des Moines in 1950, and in addition to his private practice, was involved in medical education and patient care at Broadlawns Hospital. In 1969 he terminated his private practice and devoted full time to the training of resident physicians and medical students from the U. of I. College of Medicine at Broadlawns. Dr. Sands was the author of a book entitled, "Growing Up to Love, Sex and Marriage," published in 1960 in addition to more than 20 articles in professional journals.



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Medical Assistants



by BETTY EHLERT, CMA-A

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ical (CMA-C), and pediatric (CMA-Ped). More than 7,500 certificates have been earned since the first examination was given in 1963.

The AAMA pioneered in the development of curriculum standards for medical assisting programs. The American Medical Association, in collaboration with AAMA, is recognized as an official accrediting agency for such programs by the U. S. Office of Education.

On five different occasions the AMA House of Delegates has passed resolutions commending the objectives of AAMA, endorsing its functions, and urging every physician to encourage medical assistants to join the association in order to benefit from its educational programs.

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